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ABSTRACT

This pilot project was designed to demonstrate the feasibility of exchanging professional personnel of a medical school and a community hospital as a method of stimulating the internal communications practices of physicians at the community hospital. The impact upon the attitudes and educational policies and activities of community hospital physicians was the chief focus of the program, but the effects upon the quality of medical care at the community hospital and the attitudes of the staff at Jefferson Medical College were also examined. A rotating schedule was set up and specialists from both institutions visited the other facility for a period of one week. The staff at the Community Hospital was found to be divided into two groups, teaching and nonteaching, and there was little interdepartmental cross-fertilization of ideas. The program resulted in a request by the Community Hospital for affiliation with the Medical College and in a greater awareness by the Medical College staff of the problems of physicians at community hospitals. (BC)

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FINAL REPORT

ON

CONTRACT # PH 108-66-127

DEVELOP AND EVALUATE A PROFESSIONAL EXCHANGE PROGRAM BETWEEN A
COMMUNITY HOSPITAL AND JEFFERSON MEDICAL COLLEGE

OCTOBER 1, 1966 TO JUNE 27, 1968

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Instructions to the Reader with Regard to the following Sections

In the following sections, there are multiple quotations taken from taped interviews with physicians participating in the Exchange Program. Direct quotations are presented on the yellow paper preceding the text of the report which is typed on white paper. The reader will thus have two pages of typed material in front of him at most times: Quotations on the yellow paper on the left refer to the text which is on the white paper to the right. Certain of the quotations are denoted as "Pre" and certain as "Post." This refers to whether the physician was interviewed prior to his participation in the Exchange Program or following such participation. Community hospital physicians are identified in terms of their specialty; Jefferson Medical College faculty are not identified in terms of specialty.

The following is a final report on the initial phases of a project in continuing medical education involving the exchange of practicing physicians and physician-educators between a community hospital and the Jefferson Medical College.

RATIONALE OF THE EXCHANGE PROJECT

The project was created as a pilot project designed to demonstrate the feasibility of a medical school and a community hospital exchanging professional personnel as a means of stimulating the internal communications practices of physicians at the community hospital. The impact upon the attitudes and the educational policies and activities of the community hospital physicians was the chief focus of study but attention was also directed to possible effects of the project upon the quality of medical care offered at the community hospital. In addition, interest was directed to the effects of the project upon the staff of the Jefferson Medical College, especially their attitudes towards and understanding of the problems of the physicians practicing in the community hospital.

Communication as a Measure of the Quality of Medical Care.

It was taken as a postulate that physicians in practice in the community hospital were generally as bright, as well trained for their work, and as service oriented as their medical college physician-educator peers. However, it was felt that the quality of medical care in the average

community hospital was inferior to that found in the medical college hospital. This was postulated as due to more intense communication of ideas in the medical college which is a function of the greater amount of medical education which takes place here. Consequently, it was assumed that if the level of communication in the community hospital could be raised in relation to the medical educational activities conducted there, that this would have an ultimate beneficial effect upon the quality of medical care offered to patients there.

Feasibility of Community Hospital/Medical College Exchange of Personnel.

It was recognized from the outset that the quality of medical care offered in community hospitals throughout the country is probably improving anyway as the result of a multitude of factors. The pilot project was designed, therefore, not necessarily to prove the direct effects of an exchange project upon the quality of care in the community hospital, but to demonstrate the feasibility of the approach: Was it possible for the medical school even to gain entrée into a community hospital which had remained separate from and even aloof from medical college entanglements and which had even previously turned down opportunities for developing programs in continuing education with the medical college? To what extent might the town versus gown clash interfere with an open and frank exchange of ideas by those participating in the project? Would physicians in private practice be willing to give up time from their active and profitable practices to visit the medical college for any extended period of time? Would the effect of the program be to increase the dependence of the community hospital upon the medical college or to reinforce its previous posture of self-satisfied isolated splendor? Or would it possibly prove divisive in the community hospital? Suffice it to say at this point that the approach proved to be entirely feasible: relations between the community hospital and the medical college became warm and friendly, and a spirit of cooperation prevailed throughout the period of the exchange and became closer as physicians from the two institutions became acquainted with one another.

Exchange of Personnel versus Other Approaches to Increasing Communication.

It may be wondered why an exchange of professional personnel was selected as the means of stimulating more intense communication of ideas at the community hospital and of improving the quality of medical education offered there. Certainly there are a wide variety of other approaches to continuing medical education at the community hospital which might have been considered. In fact, the Jefferson Medical College for some eight years has conducted quite successful programs in continuing medical education at approximately thirteen hospitals located mostly in the eastern half of the state of Pennsylvania. The annual attendance at these programs approaches some 7,000 registrants annually. Moreover, the programs at these hospitals are not purely didactic lectures with little or no involvement on the part of the participants but have moved to the point where local physicians are involved at all stages of planning and presentation of programs. Yet, there is reason to believe that some of the potential effectiveness of these programs is limited by the fact that they are conducted at the community hospitals for the most part and the community hospital physician participants are thus not given the experience of learning in another and more academic environment.

The community hospital is an excellent locale for programs designed to attract a large number of physicians. However, unless the atmosphere of the community hospital is very intensely oriented towards education

at other times, the effects of educational programs conducted there may not greatly change underlying attitudes towards continuing medical education. It is felt that for these to change, some rather sharp environmental changes are required and prolonged time is also needed. Furthermore, while continuing education programs may have brought some changes in educational attitudes, policy and internal activities at the community hospitals where they have been conducted have not been evaluated in any systematic way. There is also a degree of discontinuity to these programs so that the community hospital is left largely to its own devices to follow up the newer ideas which are presented.

It was therefore felt that through an educational exchange program involving both the community hospital and the medical college, it would be possible to stir up interest more quickly than through other techniques and that this could be measured and evaluated more readily. Experience with educational programs at community hospitals suggested that there is likely to be a core of potential physician educators there whose latent educational leadership would be stimulated and encouraged and who would then provide the vehicle for the transformation of the hospital. The approach taken in this project was to exchange interested younger men from the attending staff at the community hospital and to identify among them the future educational leaders of the community hospital.

Developing a Base of Physician Interest and Support for the Hospital Educational Program.

Experience with programs of continuing medical education in other hospitals has revealed what appears to be a general pattern of physician reaction. Initial reaction to educational programs tends to be enthusiastic as evidenced by large numbers of physicians who attend the educational programs when they are first presented. After about one year, this interest begins to diminish. However, as the programs are continued, there is new growth of interest and increased attendance and this eventually becomes relatively stable at a point above the initial peak. Various explanations may be offered for this apparent phenomenon. Initial interest may be related to curiosity. The physicians who maintain their interest throughout the life of the program are those who are especially devoted to their continuing medical education and who are the educational leaders of their community. Presumably, they get something of substantial value out of their participation. Eventually, the other physicians perceive that they are missing something and they become involved but on a more substantial basis than curiosity. Their involvement becomes self-regarding and the programs continue and their growth also continues. In some cases, it seems that the hard-core of interested physicians may be rather small, but as they identify one another, they support one another and from this mutual support, their strength within their institution increases. The probability, for example, of their receiving referrals would be expected to increase.

An exchange program allows those physicians who are the potential or latent educational leaders in the community hospital to be recognized as individuals, for relations to be developed and established with them, and for support to be given to them from the medical school. Where the educational leadership of the community hospital is not very active, and where there is resistance to various changes which might be desirable in developing the educational program at the community hospital, this physician base may become very important.

Such individuals can provide more vigorous and imaginative educational leadership in many instances than can the actual individuals with official positions in the educational program of the community hospital. Change, may in fact, even be inhibited by those whose official roles are to develop it. By developing a core of physicians who are increasingly eager to have first rate educational activities at their hospital, the resistance which may be anticipated can possibly be overcome or outflanked. Such individuals may begin to perceive the possibility of extending the educational program at the community hospital into "non-educational" areas. These areas could include, for example, relating the medical audit activity to the educational program. The medical audit may be extended to include not only discharged patients but patients still in the hospital. The importance of providing a house staff with outstanding educational experience may be stressed as the best way in which to attract house staff. Efforts may be made to secure the

appointment of a full-time Director of Medical Education and full-time chiefs of departments. The selection of new staff members in relation to their professional commitment to the educational program of the hospital may be encouraged. In short, from administration to patient management, the hospital can become education-oriented largely through the motive force of those interested but who are not necessarily the officially designated educational leaders of the hospital. An exchange project offers multiple opportunities for the identification and development of this kind of a devoted physician base.

Why Two-Way Exchange of Personnel?

Medical educational programs are well known in which medical college faculty go to the community hospital for varying periods of time for the purpose of conducting educational programs there. Similar programs are known in which the community hospital sends members of its attending staff to the medical college for the purpose of participating in educational programs there. This program was unique in having the exchange work both ways. It is felt that both approaches have merits and that these merits, to some extent, are independent of each other. What is accomplished one way cannot easily be accomplished the other. The medical educator going to the community hospital can explore general needs at the hospital and participate in various kinds of teaching activities. His influence, however, tends to be diluted by the large number of community hospital physicians he must relate to. The physician going to the medical college is more likely to be saturated with new ideas in the academic environment than by the diluted exposure to a single faculty member visiting his own institution. Attitudes are more likely to be changed where there is a change of environment, but return to the old environment may undo this change. Moreover, the practical problems faced at the community hospital level may not be recognized at the medical college. Advantage of both methods are likely to be maximized when the two activities are coordinated. Furthermore, the reinforcement needed to achieve change is more likely to be continuous.

Improvement of the Quality of Medical Care versus Changing the Educational Environment.

Although the underlying purpose of this project relates ultimately to improvement of patient care by all physicians at the community hospital and in the geographical area served by the community hospital, emphasis was directed initially at more short-range goals through which the long-range goals might be achieved. The immediate goals of this project were, therefore, to change the educational environment within the community hospital so that the latent educational leadership within the hospital could emerge as a viable and identifiable group which could be given external support and guidance. Given this goal, very little attention was expended in attempting to develop a formal curriculum for the participating physicians. Of course, it was known and expected that in their conversations and attendance at various programs related to the project, they would be exposed to such ideas, but the project was not structured to make this the immediate primary focus. The first phase of the exchange project between the community hospital and the medical school was thus concerned with providing the suitable conditions for attitudinal change and internal structural changes to occur. It was concerned with establishing communication with those individuals who might emerge to assume leadership roles within the community hospital which must be assumed for it to accomplish the desired transformation in terms of educational spirit, interest, and atmosphere.

Structure of the Exchange Project.

The exchange project involved the exchange of physicians between the medical school and the community hospital. The exchange was arranged as far as possible on a "rotation" schedule. The schedule was set up such that a physician from the medical school would visit the community hospital for a period of one week during which time he would observe activities of interest to him there and become acquainted with physicians or the staff doing work related to his own field of interest. He also might talk, participate in conferences, and otherwise communicate with the physicians at the community hospital.

The following week, as the medical school physician returned to the medical school, the community hospital would send one of its attending staff members to reciprocate the visit at the medical school. In theory, and most frequently in fact, the community hospital physician would be the counterpart to the visiting academic physician in terms of special medical interests. In instances, however, the community hospital had no such counterpart so that someone might be exchanged with only peripheral interest and knowledge of the academic physicians' field. In some instances, there was no physician available from the community hospital willing to participate in the exchange in a given week although this was rather rare outside of the summer months. In some instances, it was decided that there was insufficient volume of work done at the community hospital to justify sending an academic physician in a given field. It was originally planned that hospital

administrators, paramedical personnel, nurses, etc., might be exchanged but this proved to be impractical except for the rotation of one nurse from the community hospital and one nurse from the medical school. Indeed, not all of the rotations sought by the community hospital physicians could be met. During the course of one calendar year of operation some eighteen community hospital physicians participated directly in the rotation and a like number of academic physicians did so. All participants were given a stipend and were paid for their expenses. One of the community hospital physicians agreed to forego the stipend and payment of expenses when it was indicated that funds for this purpose had been exhausted.

Community hospital physicians participating in the exchange were not given any specific instructions as to what they were to do or what they were not to do during the period of their exchange. They were given complete freedom to attend classes, conferences, operations, and rounds or to communicate informally with other physicians, house staff, students, or paramedical personnel. They were given schedules of activities of interest. They were invited to visit the library at their pleasure or to examine any of the other facilities at the medical school they might be interested in. The only constraint placed upon them during

their exchange was they they were to be present at the medical school during the work week and during the work day. They were encouraged to make whatever comparisons they wished and to report their observations to their colleagues at the community hospital.

Academic physicians participating in the project from the medical school were given similar non-specific directions with regard to their role at the community hospital. It was suggested that they should not attempt to "take over" the conferences at the community hospital but to participate judiciously and to offer such information as was requested of them. They were, thus, to be available as resource people but were encouraged not to dominate discussions or otherwise upset the normal flow of activities at the community hospital. They were told to look into the area of medicine in which they had a special interest and the organization of educational and other departmental activities in which they might have some constructive insight.

Design of the Educational Experience for Participants in the Exchange Program

Because the Exchange Program schedule was so arranged in most cases that a member of the medical college faculty would visit the community hospital the week prior to a community hospital physician's visiting the medical college, this allowed the community hospital physician to become familiar with his academic counterpart and to discuss with him the kind of educational activity he would have at the medical college prior to his actually coming there. Most of the academic faculty were entertained in the homes of their community hospital physician counterparts. This provided for a kind of intimacy and warmth of relation from the outset. Consequently, most of the physicians from the community hospital knew more or less exactly what they wanted to do at the medical college upon their arrival there. It was only necessary to supply them with a list of the various conferences and other educational activities taking place at the medical college.

The majority of physicians were interested in attending meetings or other educational activities related to their area of specialization. The only exceptions to this were the two general practitioners whose interest related mostly to psychiatric matters and who asked for opportunities to meet with some of the academic psychiatrists in order to review some of their problem cases with them.

Several of the physicians were particularly interested in the mechanics of the educational programs conducted at the medical college, in the feelings and ideas of interns, residents, and medical students. Their motivation in this regard was quite clearly related to their own recognized problems in attracting house staff and their desire to see how the medical school did it.

In a great many cases, the academic "host physician" made it his responsibility to alert the visiting community hospital physician to meetings of interest and to have the community hospital physician participate in rounds with him. They were also invited to scrub-in and observe activities in the operating room where this was appropriate.

Reasons for Non-Specific Curricular Structure of the Program.

One of the chief differences between this program and other programs is that physicians participating in the exchange were given great freedom with regard to what they might do at the institution they visited.

The program may be said to be unstructured in terms of curricular objectives. The reasons for this include the following:

1. The period of the exchange was not long enough to allow a thorough exposure to any major subject area. For a community hospital physician without special training in a given subspecialty area to master it in any significant sense would require in most cases months rather than the week which was available. For a physician with some familiarity in a subspecialty area, it was not feasible to test his knowledge or skills in order to determine in advance what he needed to learn. Physicians themselves could best evaluate what they were deficient in by exposing themselves to conferences, discussions, etc.
2. The underlying goal of the project was not directed towards specific changes in physician knowledge; it was rather intended to introduce the physician to an academic atmosphere he had perhaps never experienced before as such except in the status of a medical undergraduate student. It was felt to be more important to expose physicians to models of other physicians in an academic atmosphere who were actively communicating with one another, but in which the specific information being communicated may have been of less interest to the visiting physician; interest was directed at bringing about changes in physicians' images of themselves as involved in academic and educational activities.
3. By allowing the physician freedom to pursue what he was interested in, rather than what someone else designed for him to be interested in, it was believed that his sense of involvement in his own education would be increased; it was taken as a basic assumption that learning proceeds best and is most likely to continue when it occurs as the result of the spontaneously expressed interest of an individual and which is then reinforced by later positive experiences. It was not supposed that the goal of developing the ability to learn how to learn could occur in one week under any conditions, but this experience might be consistent with some positive learning experiences the subjects previously had. The cumulative effect of having numerous individuals do so and also of being continuously exposed to the

academic model brought to the community hospital might produce the desired effect in a few individuals and encourage those already leaning in this direction.

4. By giving physicians from the community hospital freedom at the medical college to pursue their own interests for a week, they would feel more as mature physicians and less defensive in their relation with the medical school.

Selection of the Community Hospital

Much thought was given to the selection of an appropriate community hospital in which to conduct this experiment. All hospitals with which the medical school had affiliation of any sort were ruled out as contaminated for experimental purposes. This included the thirteen hospitals where the medical school had been conducting programs in continuing medical education mentioned above. All other hospitals in the state of Pennsylvania had previously been contacted in order to determine their interest in setting up such programs but had declined. Until the beginning of this program at this hospital, there was, therefore, no program in continuing medical education.

Other considerations involved in the selection of an appropriate community hospital for this project were that it should be outside of the immediate metropolitan area in which the medical school was located so as to reduce confounding factors but reasonably close so as to permit access by automobile within one or two hours. It was also decided that the hospital should be large enough to have a variety of specialty areas

represented among the attending staff and there should be several approved residency training programs conducted in various departments. The hospital should also be sufficiently large to provide potential patient population exhibiting a reasonably wide variety of pathology.

History of the Hospital and Its Place in Its Community

The community hospital selected for this project has a long and a distinguished history in its community. It has been well supported financially and by various civic groups. It is the largest hospital in its community and in its county. In a large measure, other hospitals in its community look to it for leadership even though thus far there has been only informal contact among the various hospitals in the community and because some physicians are members of the attending staff of more than one hospital in the community. The medical staff is composed of over 140 physicians about half of whom are generalists and the remainder are specialists distributed in eighteen specialty and sub-specialty areas.

Educational Activities at the Community Hospital

The community hospital traditionally conducted medical educational programs at the intern level and at the residency level in the following specialty areas:

1. Internal Medicine
2. Surgery (three year accreditation)
3. Orthopedic Surgery
4. Obstetrics and Gynecology
5. Radiology

The hospital also operated a large school of nursing and it has various training programs for medical technicians and other people in the allied health sciences. There was no program in continuing medical education.

However, the hospital had been having increasing difficulty in attracting interns and as the exchange program began, it had none whatsoever for the following year. This was perceived by community hospital physicians as something of a crisis and is probably the crucial point in explaining the interest of the community hospital physicians in the program insofar as they saw in this program an opportunity to be praised for their good work, and, therefore, to attract house staff. Otherwise, the hospital may be characterized as a conservative institution in a conservative community. Physicians were known to earn substantial incomes and could, from that point of view, be somewhat complacent about their educational program. It may be supposed that the physicians' motivation to make any basic changes in their hospital organization was reduced by the overall comfort of their situation. However, loss of interns, and to a lesser

extent, of residents, is judged to have disrupted their complacency to some extent and to have conditioned at least some individuals to reflect more critically upon their institution and their role in it.

Hospital Service

The community hospital serves a population of a quarter of a million people and has some 20,000 admissions yearly, ninety percent of whom come from the county in which the hospital is situated. It has over 600 beds but there are present plans for expansion eventually to 900 beds to meet the increasing population of the area. Although it is an older institution, it has up-to-date facilities in terms of its physical plant and considerable land space available for growth.

Medical Director/Director of Medical Education

After an exhaustive examination of all hospitals in the state of Pennsylvania meeting the above criteria, a single community hospital was selected and its Medical Director was approached. He responded immediately and with enthusiasm to the proposed project. This was the more surprising insofar as he otherwise appeared to be rather conservative and cautious in responding to new ideas. He tended, for example, to interpret lack of interest in the educational activities at the hospital more to the lack of motivation of the medical staff than to the quality of what was presented in educational meetings. As Medical Director of the hospital and also as Director of Medical Education, he was passively cooperative with the medical college personnel and their various requests, but was somewhat lacking in imagination with regard to how to make educational programs interesting to all of the personnel at the hospital. When presenting a new idea, his main mode of communication with his staff was to write a letter to each individual and then wait to see what the response would be. There never was an effort made from his office to go out and solicit response from those who failed to reply or who did not participate in the hospital's programs. At no time did he ever seize the initiative in making suggestions about the program or forward information about how the program was or was not effective in achieving anything at his hospital. Information about meetings, programs, plans, etc., were never spontaneously submitted to the medical school.

Construction of a Schedule for the Actual Exchange of Physicians

Physicians were selected at the community hospital largely on the basis of their interest in the educational program there. Of course, all participation in the program was on a voluntary basis. The Medical Director there was actually responsible for the selection of the community hospital physicians to be exchanged but he was given general guide lines including one that the physicians to be exchanged should be active and not about to retire from practice. He was also required to match the medical school physician with a community hospital physician in terms of area of specialty and subspecialty interest. In addition, he was requested to select general practitioners for whom there would be no counterpart at the medical school.

Physicians at the medical college had become accustomed to going to various community hospitals for teaching purposes. They report such experience to be interesting and rewarding. Because of their positive orientation towards continuing medical education, it is usually possible to select the most suitable individual from among a variety of individuals available.

In some areas (such as urology), it was decided in advance that there would probably not be enough for an academic visitor to do in the community for a full week and visitors were therefore received from the community hospital but not sent there. If it was known that the community hospital would be unable to send one of its staff in a specialty area, as happened in neuro-surgery, no academic visitor was sent to the

community hospital in that area. A balance was kept between surgery and internal medicine, but the larger number of specialists in the latter field led to a somewhat greater number of exchanges in that field. Although general practitioners were invited to participate, none accepted the invitation until the close of the program. At this time, because funds were exhausted for stipends, one agreed to come without stipend.

It was found that it was more difficult to attract visitors to the medical school during the summer months because this tended to interfere with vacation plans, because of the reduced number of medical students present at the medical college in the summer and the desire of many of the community hospital physicians to make contact with them, and because of the frequently unpleasantly warm weather during the summer at the medical college. The full list of exchange visitors follows:

JEFFERSON - READING EXCHANGE

<u>INCLUSIVE DATES</u>	<u>JEFFERSON VISITORS</u>	<u>SPECIALTY</u>	<u>READING VISITORS</u>	<u>SPECIALTY</u>
March 6-10, 1967 March 13-17, 1967	Dr. Rupp	Medicine-Endocrinology	Dr. Reifsnnyder	Medicine-Endocrinology
March 20-24, 1967 March 27-31, 1967	Dr. Camishion	Surgery - Cardiac	Dr. Cohn	Surgery - Thoracic
April 3-7, 1967 April 10-14, 1967	Dr. Simerhoff	Medicine-Renal	Dr. Shultz	Pathology
April 17-21, 1967	Dr. Delaney	Pathology		
May 1-5, 1967	Dr. Jackson	Medicine-Genetics-Cancer		
May 8-12, 1967			Dr. Wornas	Medicine
May 15-19, 1967	Dr. Abruzzo	Medicine-Rheumatology		
May 22-26, 1967			Dr. Rowen	Medicine-Cancer
June 5-9, 1967 June 12-16, 1967	Dr. Nealon	Surgery-Pulmonary	Dr. Pernig	General Surgery
June 19-23, 1967 June 26-30, 1967	Dr. Fraimow	Medicine-Chest Diseases	Dr. MacShane	Medicine and Director of Medical Education
July 5-7, 1967 July 10-14, 1967	Dr. Goldstein	Medicine - GI	Dr. Hoyt	Medicine - GI
September 11-15, 1967 September 18-22, 1967	Dr. Bailey	Pediatrics	Dr. Paolini Dr. Youngberg	Pediatrics Physical Rehabilitation

<u>INCLUSIVE DATES</u>	<u>JEFFERSON VISITORS</u>	<u>SPECIALTY</u>	<u>READING VISITORS</u>	<u>SPECIALTY</u>
September 25-29, 1967 October 2-6, 1967	Dr. Pierucci	General Surgery	Dr. Morrow	General Surgery
October 16-20, 1967 October 23-27, 1967	Miss Evans Dr. Gabuzda	Nurse Medicine-Hematology	Mrs. Buck	Nurse
October 30 - November 3, 1967			Dr. Rettew	Hematology
November 13-17, 1967			Dr. Sexton Dr. Summons	Ob-Gyn Urology
November 20-24, 1967	Dr. Holly	Ob-Gyn		
November 27-December 1, 1967			Dr. Yund	Orthopedic Surgery
December 18-22, 1967	Dr. Padula	Surgery-General		
January 28-Feb. 2, 1968	Dr. Killough	Medicine - Cardiology Associate Dean		
February 5-9, 1968			Dr. Oplinger Dr. Weaver	General Practice General Practice
March 4-8, 1968	Dr. Hodes	Radiology		

Physician Interview

All physicians, both medical college and community hospital, were interviewed prior to their participation in the exchange program and following it by the educational psychologist who also administered pre- and post- surveys of attitudes which were related to medical education and medical practice. All interviews were tape recorded. Many physicians, especially the academic physicians, were somewhat puzzled by what was "expected" of them, but all easily and quickly adjusted to their roles as visitors in the respective institutions.

Medical School Personnel

The exchange project was administered from the medical school with a minimum of personnel. These consisted of a director (associate dean in charge of continuing medical education), educational psychologist, and secretary. Contact was maintained with the community hospital through conventional means (letter, phone, and monthly or bi-monthly visitation).

Time Table

The time table for this project was originally set for twenty-one months as a pilot project to test the feasibility for a controlled study to be conducted subsequently. The original planning allowed for a six months "tooling up" period during which time the strategy of the exchange would be devised, and final arrangements would be made with the

community hospital for the exchange of personnel. Some delay in the actual starting date of the project was encountered due to recruiting problems. The planning period was followed by a twelve month operational period during which the community hospital physicians and medical college hospital physicians were exchanged.

Following this exchange period, a three month period for the evaluation of the program was set up. This period of time proved to be inadequate however because not all of the data pertinent to the project could be collected and analyzed without extended delays.

Summary of Communications Deficits Observed at the Community Hospital

1. The staff is virtually hermetically sealed off between the teaching group and the non-teaching group. There is little effective, continuous, consistent communication between these two groups. The gulf between the two groups is probably increasing.
2. There is very little inter-departmental cross fertilization of ideas. Conferences are organized on a departmental basis in relation to the teaching program and there is not much cross over of activity or ideas from one department to another.
3. There is poor organization of effort, little planning of teaching activities, little guidance for house staff, little delegation of authority with regard to educational activities, little integration of the overall educational program at the community hospital.
4. There is a general failure to produce imaginative responses to external stimulation. There is no effort to evaluate programs in terms of needs of physicians or in terms of effects of programs upon physician practice. The medical audit activity is only concerned with gross deficiency and is not integrated into the overall educational program.
5. There is a lack of overall educational direction from above and chiefs of departments have their time too much occupied by practice demands to attend adequately to the educational requirements of their departments.
6. Little or no attention is directed systematically to improving the quality of conferences in order to attract larger numbers of practicing physicians.
7. There is no effective committee structure to channel ideas and suggestions for educational programs and activities to the appropriate administrative levels. There is an absence of perception of the hospital as an educational institution with its own goals, budget, personnel, etc., in harmony with the overall goals and interests of the hospital.

Footnote (4), to page 28

Community Hospital Physician, Obstetrician Pre

The problem of getting too busy is a major one. This is the weakness in the program in departments which do not have a full residency program, where the pressure of the department director is not on to keep the teaching requirement up to date.

It's wonderful. He said that they told the disgruntled men that if they didn't like it, they could go somewhere else. I don't know how this would work at our hospital. Things have to change. You have to have a head of something.

Footnote (3), to page 28

Community Hospital Physician, Director of Medical Education. Post

I think the community hospital has an educational role not only to the doctors but to the community. In teaching the doctor, they certainly get better medical care. At the community hospital, our intern committee has felt that we should pursue a course that we would continue to take interns. Before we can do this, a number of changes have to be made. We've had a couple meetings about the problem of not having any interns. There are some who say, "So what!." These are people who don't attend the conferences; they are a group that have not become close to the intern. All the interns rotated through pediatrics. I enjoyed this. Granted you did not always have the time available but you try at least to give them a certain amount of responsibility and guidance. I think any hospital, when you stop getting interns or stop having people around asking questions, becomes stagnant.

The feeling of the rest of the group was to get someone to coordinate all of the education, to get chiefs of medical service someone perhaps who was retiring from a medical school. We also thought about getting chiefs of medical services. There were some who had a lot of antagonism against this. It's going to be a matter of educating the doctors and the staff. I spoke to a man from another community hospital here yesterday who told me that they have a full time director of pediatrics.

Our conferences were largely geared to the training of the intern. We aren't discussing now at the basic science level. Our conference quality is not as good. We are spending more time now in discussing administrative matters which could be handled in other ways. I think the other departments reacted the same way.

Community Hospital Physician, Internist Pre

There is nothing worse for a hospital than not to have interns and residents. The administrators of our hospital realize that they are important to us. I think we have some physicians who say that they are not worth the effort of getting them. But this is a very horrible attitude and there would be nothing worse for us to lose our residents. The advantage of having interns and residents is that if the doctor is to impart some sort of knowledge, it is requisite that he has the knowledge first. He realizes that if he is discussing something with an individual who is just out of medical school and who has been in contact with well trained teachers, the staff member now has to keep abreast of what is going on. If physicians keep up through other devices, they are very reluctant to impart any of this knowledge.

Footnote (2), to page 23

Community Hospital Physician, Surgeon Pre

The greatest stimulus for continuing education is to continue as a teaching institution, to have interns and residents. This is where we learn most, talking with the other fellows who are interns and residents. They will bring up aspects we haven't even considered or they will bring a new concept from medical school. It stimulates us to attend meetings.

Community Hospital Physician, Internist Pre

We need more doctors, more specialists, and more education. We need a director of medical education. There should be a separate medical director. To get more medical education, we need to educate the public, the doctors, the board of trustees of the hospital. House staff is difficult to get today. Some doctors don't feel it is worth the effort to get interns. I think when a hospital does not have interns and residents, they definitely go backwards.

Community Hospital Physician, Obstetrician Pre

We're very proud of our three year residency program and I think this is the key to all of our enthusiasm.

The absence of interns in our department has been a definite let down.

If a doctor is to have incentive to keep up, there should be some outlet for what he learns. If you are in an institution where someone will stop you several times a day, you will endeavor not to have too many questions you can't answer. The availability of questions is an inducement.

want to be bothered. Dr. _____ turned it down; he is very lukewarm to our endeavors. It annoys me a little because he has ability and he doesn't use his own talents to his own betterment. I believe the one who gains most from our teaching endeavors is the attendant physician who puts on the hour. You would think that others would take a chance and try. We ask them to take a session, a CPC they will not. One general practitioner who did take a CPC six months ago did very well. He is one who attends our conferences very faithfully; this makes him a little different. I think the CPC is nice because it allows anyone in the audience to agree or disagree. About the first of the year we doubled the number of CPC meetings.

Community Hospital Physician, Internist Post

The biggest benefit which can be derived by our hospital by having house staff is a benefit derived by the staff itself. This is the source of their continuing education; this is the incentive for them to continue on. Otherwise they will go backwards.

A resident or an intern likes a doctor who is conversant with current literature. Quoting the literature impresses these individuals. The teaching doctor strives to do this but it is very difficult to do. But I have the impression that the physicians here read because of the interest in the topic, not to impress some one. This also tends to open the student up to be more attentive and receptive to what he is told.

Community Hospital Physician, Pediatrician Pre

Anyone can attend our pediatrics conferences but usually no one comes. We exchange ideas among the three or four of us; it would be better to have twenty. We could not support a resident up there. It would be wonderful to have a resident. We just don't have the pediatric subspecialties. When we had interns, they participated; it was enjoyable. There is a marked difference since. The feeling of presentation is different when you have some students. This always gives you the impetus to do better.

Community Hospital Physician, Internist Pre

In our area the general practitioner has an income that is equal to or above that of the average specialist. Their hours may be a little longer. I think the one who is giving the time up is interested in learning, is interested in keeping abreast with what is being done, and is interested in transferring this knowledge to student groups.

We subscribe to Audio Digest and I think it is money well spent. I have never seen any of the general practitioners listening to these tapes. I have seen house staff or physicians from the teaching group. We have asked some of the general practitioners if they would like to come down here on occasion but none of them have accepted the opportunity. We do have just a little bit of difficulty with our own teaching group in getting some of them to come down. I don't know if they didn't

Footnote (1), to page 28

Community Hospital Physician, General Practitioner Pre

Dr. _____ selected my partner and myself to participate in the teaching of interns but I don't know why. Teaching is on a one to one or one to two basis. Teaching keeps you on the ball. About six out of forty general practitioners are involved in the teaching program. All of these tend to be younger men. This would not be good for the older men because they practice a little different brand of medicine. They refer more patients. In theory it would be desirable but not in practice. This could be overcome through continuing medical education. Continuing medical education is necessary or else you will end up the way these people have ended up.

Community Hospital Physician, General Practitioner Post

The reason I don't want the house staff to fail at my community hospital is because they force you to take a more active part as far as your (own) learning goes. Anytime you prepare a lecture, you definitely retain things a lot longer.

Community Hospital Physician, Surgeon Pre

I don't spend enough time in our teaching program. I do feel that as one teaches, one improves one's own knowledge, and gives better patient care. A teaching department with everyone participating will lead to a higher calibre of surgical practice.

The Pattern of Communication and of Continuing Education in the Community Hospital

Professional communication and the educational program at the community hospital are very closely associated with each other through the hospital's house staff training program. The impression obtained is that the community hospital physicians are not greatly interested in teaching one another, but have some interest in teaching the house staff and perhaps learning something themselves incidentally. (1)

The presence of house staff therefore justifies physicians' participation in the medical conferences and other teaching activities for those who do so. (2)

Consequently, there is a very high correlation between attendance at educational functions and participation in the teaching program at the community hospital. For all practical purposes, the conferences at the hospital are attended only by physicians who participate in the teaching program for the house staff and the conferences are the major formal educational activity directed at the house staff. (3) The implication which follows from this is that the pattern of professional communication within the community hospital is tied to its educational program and for the most part the continuing education program at the community hospital is incidental to the training of the house staff. (4)

It is interesting to note the ambivalence of the hospital direction and

Jefferson Medical Center Physician Post

I found poor supervision of residents. This is interesting because the number one item ranked by interns in their evaluation of training programs is supervision. This is the one thing that is missing at the community hospital. It is better to have this come to the attention of their medical director through other people.

an appropriate specialized environment which they do not have. They do in ob-gyn.

Jefferson Medical Center Physician, Post

There is sufficient clinical material, both private and ward, to justify a residency. One resident, however, is overwhelmed by things that should be done at the first year level. If the senior resident wanted to fire up the ovens, just using the wards, there is plenty for him to do. It was difficult to evaluate the program however because one of the residents was not too well organized. When you come down to it, the resident is a glorified nurse. His main function is to get something on the chart. It is hard for him to make decisions. On the other hand, the nurses there behave in the operating room as interns or residents do here. He does very little to participate in the operation.

From what I saw in the community hospital, there are some individuals there who are well motivated as medical teachers. With some of them, however, the student would take over the role of the nurse who is simply holding a retractor. But it would be a very good thing for both sides to have medical students there. They have inquisitive minds and don't stand for a long time without asking why. Some of their doctors might really become rattled by this experience.

means of survival. If the latter, when he gets his privilege to practice, he is not particularly interested. He may not have been too interested in medicine from the very beginning.

Community Hospital Physician, Pediatrician Pre

I have no evidence that the general practitioners who do not attend our conferences spend that time in self-education.

Community Hospital Physician, Pediatrician Post

I have tapes I listen to. I buy them. We could have taped the conference with Dr. _____. I think that if you couldn't get a man to conference, you would never get him to listen to a tape. They have all the tapes there and tape recorders. They don't listen to them. They wouldn't listen to tapes of our conferences.

Community Hospital Physician, General Practitioner Pre

Some of the general practitioners just aren't interested in participating in the educational activities at the community hospital. They are so busy that they don't really care. The older men feel they only have a few years left to practice, so why should they worry about what the other people are teaching? I care because I want to continue my practice the way I think it should be done. I know that in order to do this, I have to continue my education. When an intern fresh from medical school starts popping questions I can't answer, it will force me to go to the books.

Footnote (3), to page 29

Community Hospital Physician, Internist Pre

We are in a very horrible position at the moment. We have no interns.

This puts us in a difficult position for 24 hour patient coverage.

We made up a list of those admitting medical patients into the hospital and we are asking them to give coverage for the evening hours.

The physicians participating in the exchange program we have no trouble with. They are perfectly willing to take their turn. It is the individual who comes to the hospital for a short time to see a patient who doesn't want to do this. We have a meeting of physicians disturbed about this. Ninety-five per cent of them never attend any committee meetings. About 15 men were present. They said they never had any intern coverage anyway so they couldn't see how it was any different for them. They can't realize that because they didn't have an intern assigned to their patients, still in the event of a serious emergency there was an intern who would go down to see their patients. I don't think they were convinced.

The vast percentage of the physicians who came to our special movies, etc., are the ones who come to our other things. We don't get any new group.

Community Hospital Physician, Internist Post

As far as a physician's keeping up, I think a doctor either has it or he doesn't. He's either interested in medicine as such or as a

Footnote (2), to page 29

Community Hospital Physician, Physical Therapist Pre

Being a teacher gives you a sense that your ultimate accomplishment is more than just the service you are giving. There is no question that it stimulates you. I would say however that the nurses and physical therapy students are not as demanding or critical as medical students. You know, the word doctor comes from the word that means teacher. A lot of our work too is in teaching patients and teaching family. In our work, if we are successful, it is because the patient works. We have to have the active cooperation of the patient.

Community Hospital Physician, Internist Pre

I saw how two way communication can bog down through misinterpretation as a medical resident. I could talk to patients and to doctors and get each one's side of the story. It opened my eyes to how important it is to be able to talk and to listen. Doctors use words the patients can't understand. He may not have time to explain things. The attitude of patient to doctor may change because of this. Many medical problems could be solved if doctors and patients could talk and listen to each other.

ence with Dr. _____ because we thought the medical men would be interested but we couldn't get a common time.

inclination to be interested in answering the interns questions, we have in the past assigned him an intern. This has been very rewarding in some instances. Most of them will not accept this. I found this out in trying to get some men to teach nurses. They would say that they didn't really know enough about the subject to discuss it. If they won't discuss it with nurses, they won't with house staff. It is easier to do it yourself than to prevail on someone to do it for you. Those who spend time teaching are those who accept doing it. It isn't that they feel we don't want them but that they don't want to be bothered.

Community Hospital Physician, Pediatrician Post

I don't ask the doctors who don't come to conference why they don't because I feel it is their business. I wouldn't feel comfortable. I may say to a man that I didn't see him at the concert last night but I don't ask about their going to the pediatrics meetings because I've accepted that nobody goes, except the three of us. We had five people for Dr. Bailey. Had we called everybody on the phone, this might have brought more people. There is a law of diminishing returns. I won't sit on the phone calling everybody. Maybe if the caliber improves by getting people from the outside and somebody wanders in and by word of mouth people know they have good speakers and conferences, we might get more. You'll have to call up a few people personally and get them to come in and hope they will do the same. We wanted a joint confer-

Footnote (1), to page 29

Community Hospital Physician, Director of Medical Education Pre

About 50 members of the staff are members of the teaching staff here. They all aren't used. So the intern has an opportunity to select electives and things like this. The neurosurgeons, ophthalmologist, and otolaryngologist aren't used very often. I think it is a distinction or has some advantage to be part of the teaching staff. People come and say, "Why can't I get on?" If they are capable and we have a house staff that is big enough, they are put on. Having house staff coverage does not save physicians any time; it takes longer to teach a man than to take care of a patient. The only advantage is the patient is covered when you are not there and that you are stimulated by the teaching. The older men don't care if they are not members of the teaching staff but the younger men are disappointed if they aren't. I can't imagine a time when all physicians at the community hospital would be teaching. Some aren't interested and some aren't capable of imparting information.

Community Hospital Physician, Internist Pre

The teaching staff now is composed of those doctors who are in charge of ward service patients and these are those physicians who are board certified in internal medicine. But in the past we have had general practitioners to whom we did not assign an intern if he has shown an

of the physicians, however, with regard to using the teaching program at the community hospital as a device to bring a larger number of physicians to the hospital's educational program from the attending staff. (1)

The director of the hospital has apparently not recognized as some of the physicians on the staff there have that there is a relation between teaching and practicing medicine itself. The doctor is often called upon to impart information to patients. (2)

In a sense, therefore, the staff can be divided between those physicians who are active as teachers and those who are not, and this may be related not only to their patterns of attendance at conferences, but to their participation in other educational activities, their utilization of the hospital, and not unlikely to the pattern of their practice of medicine. (3)

Although it is reasonable to believe that house staff training programs are of great value to the attending staff physicians at the community hospital because of the incentives thus placed upon the learning of the latter, much depends upon how much effort and imagination the attending staff is prepared to put into its teaching activities. (4)

There is no evidence of any formal preparation for hospital conferences at the community hospital except for occasional mimeographed case material

and for individual efforts made in the Department of Obstetrics and Gynecology as reported above. There is virtually no delegation of responsibility to X-ray or Pathology Departments to have available well defined material pertaining to the case under discussion. In fact, attendance by X-ray Department and Pathology Department physicians at the medical conferences is not a frequent event and they are rarely called upon to contribute to the discussion when they do attend.

The brunt of the conference activity thus falls upon the residents who actually present the case material and upon a small handful of physicians who are knowledgeable more or less by chance about the subject under discussion. The residents are given very little if any instruction in how they should present case material and their presentations are often inadequate as a result. Conferences, therefore, tend to be rather "hit-and-miss" affairs and it is small wonder that most physicians avoid them. In fact, most physicians never attend any of the conferences at all except for the few who are especially concerned with the educational program at the hospital.

Given the intense desire on the part of the teaching staff of the community hospital for the house staff training programs to continue, surprisingly little attention has apparently been expended in developing the educational program there as a means of attracting good house staff. Community hospital physicians do not appear to perceive their weaknesses

Footnote (4), to page 31

Community Hospital Physician, Pediatrician Pre

I don't know how much our hospital is a service institution and how much an educational institution; I would feel it is more a service institution. I don't know how you find out how much--how do you put a percentage on this? You can also perceive it as both.

Community Hospital Physician, Internist Post

It must not be a very great percentage of physicians who recognize the hospital as an educational institution. But of those who help determine hospital policy, it is more sizeable. They realize they must do this if they are to remain on a par with sister hospitals.

Community Hospital Physician, Surgeon Post

I am not clear about the responsibilities of the Medical Director and the Director of Medical Education. They are not clearly and sharply delineated.

although this includes expenses. One fellow five years out of medical school earns \$75,000 a year in my group. I don't think that people in academic capacities earn this much.

Community Hospital Physician, Director of Medical Education Post:

I would say that the average academic physician would make 50% or less than what the community hospital physician makes. I'm not talking about the ones hired by the hospital. Hospital based physicians do about the same I would say. We're a low paying hospital. It's always been a low paying hospital. Every now and then someone grumbles but they don't leave. In most cases we can attract the new people we would like, so far.

Footnote (3), to page 31

Community Hospital Physician, Internist Post

In the community hospital, the individual who may be an excellent teacher often has a patient load which precludes to some degree his taking time for his teaching. This is not so true in the university hospitals. At the community hospital the intern or resident may get an answer but he may get the feeling that the teacher is very busy and is not too happy taking his time. They don't mean to be short but it is related to the fact that they have patients to take care of in order to make a living. Dr. _____ gets very cross at our staff because many of our conferences are less well attended than they should be. The same faces are there day after day. That's one reason why I think there are more full time men in medicine and surgery. For the moment we feel these are the two departments most likely to attract students to our hospital. I think this is the main motivation in our wanting to hire these people. We would like an individual well versed in his field but not an intellectual giant.

Community Hospital Physician, Surgeon Post

I have an idea of academic salaries based upon our own search for a director of the department of surgery. We will pay \$40,000 a year, \$30,000 paid and \$20,000 earned. The rest goes into the kitty. This is comparable to what the average surgeon gets. I earn over \$100,000

Community Hospital Physician, Director of Medical Education Post

High quality internships are still hard to get. These are in medical schools because most of them like medical schools. .I didn't learn anything about the internships at Jefferson that we don't know about. The object is to put it into practice, to have quality teachers who have the time to guide and cajole these young physicians. This is the problem. We could offer a better internship if we could just have some of your subspecialists, as teachers and consultants. You need good people, subspecialists, and time. We could offer a better internship by not having the medical students. We could offer more responsibilities.

Community Hospital Physician, Internist Pre

Changes will relate mostly to the new individuals we are importing such as the full time head of the department of surgery we are planning to get. This individual will run the department and take care of a sizeable portion of the teaching program. It is difficult for a busy surgeon to give time to teaching. It would be different if he were employed full time by the hospital. We now have permission from the Board of Managers of the hospital to search for someone interested in being full time. The same thing applies to medicine. Running a department is not as simple as it was 10 or 15 years ago. It demands a lot of time and consideration on the part of the one doing it. He does this because of his interest in the hospital and in the student group he has. I'm not against not being reimbursed but it is becoming such a major task that it has to be different in future.

It will be a tremendous advantage for our hospital to have full time heads of major departments. He would have an opportunity to go to various medical schools in the state to teach to students and to sell the hospital... I think we have a good hospital but there is not much salesmanship behind it. You can't do this with a person trying to make a living each day. The Board of Managers has said that they want us to discuss this further if we think this is right. But the hospital cannot afford this without making an adjustment on the patient's charge.

Footnote (2), to page 31

Community Hospital Physician, Surgeon Pre

I'm interested in the newer concepts of medical education with the training of an individual in a specialty earlier in his career. I'm interested in the effect this will have on the community hospital. I'm interested in the disappearance of the rotating internship and perhaps the internship altogether. It was the most valuable year of my training without a doubt. It allows you to put together everything you've been taught in medical school.

Community Hospital Physician, Internist Pre

If we can have full time men, then we will have arrived. We have been lacking in adequate full time teaching medical doctors. This will be stimulating to the attending doctors so they will make more effort to get to the conferences. I feel this is likely to be forthcoming in the future. We will get money from the board of Trustees. The public is more understanding. The biggest problem is the actual availability of personnel. There just aren't enough doctors.

Community Hospital Physician, Surgeon Pre

One of the jobs of a department director would be to run the educational program in the department. The present Director of Medical Education cannot really run the program in various departments.

Jefferson Medical Center Physician, Post

They were more interested in what we are doing down here and on the surface at least they did not seem to be actively looking for solutions to their own educational problems. They did not ask my opinion as to what should be done on the various problems. The main problem comes from the fact that there is no top. They could have an educational program without a full time head if they had the right person, and the full understanding of the rest of the group. An important motivating factor would be the effect on the individual's reputation.

Footnote (1), to page 31

Community Hospital Physician, Surgeon Pre

For the first time in the history of the community hospital there were no interns. This is because the hospital administration does not have enough aggressiveness to obtain interns. That is the only reason. The medical director says that with a good teaching program they will come but I don't think this is true. We have now increased the salaries (double) and the socialization. At one time the attending staff was never allowed to entertain interns. This was some eight to ten years ago. This was based upon fear of competition. It was felt that such entertainment was unethical.

Community Hospital Physician, Pediatrician Post

There are only so many hours in a day. If you like one thing better than another, you have to rob something else. Sometimes a heavy handed way is the only way to do it. Now, if your medical records are not finished at the end of a month, you lose all admitting privileges. Everybody who could never get to the records room got there. They have to do it. It's important. But it may not be as important to attend conferences. If they felt the conferences weren't any good, they would put us on the spot.

in this regard; some seize superficial explanations for their problems. It is not unlikely that correction of the basic problems would involve some disruption in the form of practice in which the physicians participate. (1)

The Exchange Program apparently did stimulate considerable thought about the subject of the relation between getting interns and residents and the kind of educational opportunity which should be available to them at the community hospital. Some men even came with this as their announced area of principal interest and some had ideas about their needs in this regard. (2)

It may be inferred from the above that the principal motivation of physicians in wanting full time heads of departments and the like is to free themselves from the chores of teaching while yet reaping the benefits. This would allow them more time for their already busy practices. In this regard it is interesting to note that the field which was apparently the most lucrative was the least organized educationally (apart from general practice which was also disorganized but lucrative). The income of one surgeon for one year, it may be noted, could fund the entire Exchange Program for two years. (3)

In general, therefore, it may be concluded that there is no deep perception in this community hospital of its role as an educational institution nor of the roles of various individuals in the hospital as educators. (4)

A Director of Medical Education would have to be tactful working with independent physicians. In time the older men would retire or die off and the others would realize this is the only way. We have to have specialists capable of bringing the wonderful advancements to all of the patients. In our area I think the independent practitioner is on his way out. The young man today would look askance at the hospital that doesn't have a full time Director of Medical Education.

Our hospital is large enough that we need more hospital based physicians in addition to our radiologists, anesthesiologists, and pathologists. We have no full time medical man in the hospital. I think in the future we will have offices in the hospital. I like office practice but I may fit into this. A director of medical education who can better synchronize the time of the available staff men with the house staff would certainly lead to better medicine.

Footnote (3), to page 32

Community Hospital Physician, Surgeon Pre

I like teaching very much. The status of the residency program in surgery is lousy. It's very, very poor. We have not been able to acquire enough residents in our own program. It's a vicious cycle. We have not been able to get any residents because we don't have an approval for a four year program and vice versa. We have an adequate amount of material. There are seven active general surgeons on our staff. About half are interested in teaching to the point of participating actively in the teaching. We feel we have to go one way or another. We want to continue as a teaching institution. For our staff to better themselves we should have relations with teaching. This is essential. We lack a chief in our department. We have had four chiefs for the past four years. I don't think it has worked out very well. This has led to some lack of communication in our department.

Community Hospital Physician, Surgeon Pre

I have been asking around to find out what the criteria are to get approval for a four year program.

Community Hospital Physician, Internist Pre

I have seen where a new specialist who was up to date was a threat to the security of some of the men. There might be some problems depending on how much politics there is in the selection of a new man.

what we have, he said this is exactly what he wants. I think that their visiting surgeon has already been getting ideas from his visit. I feel that we got ideas from each other.

I think there is a pretty good exchange of information in the medical conferences. The ob-gyn department is pretty well solidified also. There seemed to be organizational problems however in the department of surgery.

Footnote (2), to page 32

Community Hospital Physician, Obstetrician Pre

The surgical conference has not been good. Although I do not belong to this department, I go frequently in order to support it. It has been critized by the members of the department on the basis that it was not well prepared or attended. The chief of the department has felt this should be a resident's conference and the men in the department are not willing to spend the hours necessary to get a conference together. We have found, however, that the few conferences that have been well accepted have been worked up by residents, and discussed by the staff man who read the current literature. In surgery, the men do not feel the need to put on the best conference possible because they haven't any power breathing on them. They have a loose conference, a discussion type of conference with poor attendance and many physicians tardy. This is one of their biggest problems related to their inability to get a full four year surgical residency training program approval. Their chief is concerned but is not being backed adequately.

Jefferson Medical Center Physician, Post

There is no solid structure in the department of surgery. They are trying to correct this. They should have a departmental library conference area which they do not have. When the visiting surgeon saw

you who are interested in learning. Through this association you yourself learn. I would not want to see our hospital stop teaching. I would like to see us progress and do it to a greater degree than we have been doing it. I think this type of atmosphere is most suitable for a community hospital and most doctors will accept this type of atmosphere. But there are always those who have no desire to advance themselves.

Footnote (1), to page 32

Community Hospital Physician, Surgeon Post

Without being in a strict academic atmosphere, one doesn't become indifferent but more occupied with one's own problems. You do what the leader asks you to do, but not too much on your own. You have the feeling that that is someone else's territory. I have never had any interest in academic life except to the extent that I want to feel competent in what I am doing. If I feel I need it, I will go out and get the information somewhere. Every year since I have been in practice, I have gone away for at least week, as to the College of Surgeons, or more recently, to the AMA. I think I have taken off a little more time than the rest of the people.

Community Hospital Physician, Surgeon Post

The feeling that I have come away with is that the atmosphere of a teaching institution is so much different from the atmosphere of a non-teaching institution. If any hospital wants to give better care to their patients, a certain amount of teaching has to be incorporated within their hospital program. It's more stimulating whenever you have a teaching atmosphere. Whenever I have to make rounds with my patients with house staff, they get more out of it and I get more out of it. It stimulates you in a different way of practicing medicine. You ask yourself more questions, because you have individuals around

These feelings are even more clearly reflected in statements given by community hospital physicians with regard to their enjoyment of the "academic atmosphere" of the medical college in contrast with that of their own institution. (1)

Because the hospital as a whole is not organized effectively around educational goals, the educational programs there are likely to be functions of the interest and dedication of the director of medical education or the individual in charge of educational activities in each department. Consequently, there was expected to be and there was in fact, considerable variation in the educational program for different departments. The surgeons, according to the general consensus, had the weakest department and the weakest communications. (2)

The lack of educational organization in the department of surgery already confronted that department with the probability of losing accreditation for their resident training program. The attitudes of surgeons towards their organizational defects were remarkably varied. The acting chief of the department was somewhat superficial in his approach to the problem in contrast to the frankness of a more junior surgeon. (3)

Although the "full time chief" idea was entertained in the department of surgery, feelings here were considerably more ambivalent than in

Footnote (3), to page 33

Community Hospital Physician, Obstetrician Pre

A condition for a physician coming to our department is that he participate in the teaching at the hospital. No formal requirements are set as to the number of hours taught, but working out our four man group, each man is in the hospital every four days for a 24 hour period, is expected to make rounds with the resident, and to be a consultant to him on the ward and in the clinic, to instruct interns when they are there, to give continuous teaching to the student nurses. This means about two hours a day in some form of teaching.

In our department, there is a rotation of conferences; we all try to do the very best we can in putting on a conference. This may take hours of preparation.

Jefferson Medical Center Physician, Post

Because the ob-gyn department is better organized, there are more men there who would lend themselves to teaching medical students. This might also include their orthopedic surgery department.

Community Hospital Physician, Pediatrician Post

In the ob-gyn department, they work things a little different. They have some one there 24 hours a day for consultation work.

Jefferson Medical Center Physician, Post

The presentations in medicine were not as thorough and gave the feeling that it was a short cut sort of thing, going through the motions to satisfy accreditation. People who are being trained need exposure to others who are also being trained so they can argue and exchange ideas. One man cannot do this especially if he is overworked.

The great deficit is in planning for the area for their own continuing education. They don't have the time to spend with residents and so they just go through the motions. With rare exception the case presentations were mediocre. The resident who comes from the University of Pennsylvania was different. They themselves know these could be improved but there is an inertia.

Community Hospital Physician, Post

Overall the conferences here and at the community hospitals are quite similar except you go into more minutia. It depends on who is at our conference. If someone who is up on something happens to be there, it may be brought out.

a few number of residents, they should be even better than ours having opportunity to do this frequently.

Community Hospital Physician, Internist Post

As far as oral communications are concerned, I feel in the community hospital we do have oral communications that are sound. We are small enough to know almost everybody on the staff. We don't use the telephone enough in our daily practice. I don't feel we are deficient in journals but we may be weak in cataloging topics. I reindoctrinated myself on the importance of the library. If I knew how to interest and motivate a wider range of physicians to participate in the educational activities at the hospital, I would really be famous. Paramedical personnel are becoming important here to release the physician to have some time for communication. I would like to know how to get the men in general practice to use that three hours a week. Our specialty conferences are attended only by the nucleus, the core, but our other conferences are fairly well attended. This is not something I could stimulate another man into doing. A man has to be self-motivated up to a point. If he is not willing to learn, I can't make him. If our conferences are good and attractive, they will come. It's a question of the number of hours in the day. If we post the conferences in advance as you do here--we try but we don't do it as much as we can--sometimes we're organized and sometimes not. Usually the Thursday medical conference could be planned.

tightened up. They do not need separate programs for interns and for residents and another for the staff itself. They have on paper very adequate schedule of educational activities. What they need to do is to approach these activities more seriously and make them pleasing and rewarding. Presently, if there is going to be a conference, the house officer knows the patient to be discussed, but nobody meets with him to discuss how to structure the program. Sometimes they have to be told specifically what to include. The conferences are not planned as they are here. New house staff is taught how to make the presentation right off the bat, on a daily basis. They are taught to commit to memory the outstanding aspects of the patient's background. They have to decide who is going to be responsible for presenting various aspects of the case. If the patient is selected for a reason--and they are not presented just to occupy time--he may be unusual or he may have been mishandled somehow--it is then necessary to have a preconceived notion of what aspects should be emphasized and this calls for calling on different doctors and letting them know in advance that the patient will be presented. The doctor should then be asked to lead a discussion on certain aspects of the patient's condition. Laboratory findings should be given, the radiologist should be there and should be told what one is after. Things cannot function if they are badly organized as at the community hospital. One of their men is good at doing this extemporaneously but he only did this one time out of three or four and he cannot sustain the whole discussion. With

Footnote (2), to page 33

Jefferson Medical Center Physician, Post

It should not take over ten minutes to organize a conference for the following day if your sole responsibility is to get it organized. Knowing who the patient is and what doctors are going to be assigned to bring out various aspects of the patient's condition. If one uses enough people so that the burden does not come too frequently on one person, even if it took two hours in the library looking up various tidbits this is only as long as television programs. The physicians are not that rushed. They don't dash around and they take long coffee breaks. They don't race as much there as they do here. The generalists may be so pressed but not the specialists. The general practitioners are doing much of what a good mother might do or even a good nurse.

This program has not had sufficient momentum to be self generating as a continuing program on its own. At this stage, if the people who were so stimulated down here were in control they could probably tighten things up in terms of practice and educational standards. Although they have the concept they do not have the influence over the administration or perhaps even with the staff in general. They can't put through some of the changes which are needed. What they need now is some outside support. This does not mean there must be better ideas on the outside but they need the outside authority to make it possible to introduce changes. Their whole educational program needs to be

man, the rest of them thought it was a good idea. A few in other departments wondered why it was necessary. Only about 10% paid any attention to it at all but everyone was notified. Some came and said they needed it in other services too. I think that on the whole the staff supports it, even though they appreciate that it is going to cost the hospital.

Community Hospital Physician, Obstetrician Pre

The reluctance to bring in trained outsiders as heads of departments is waning.

Community Hospital Physician, Internist Post

We need a majority of the directing staff in order to get the consent of the Board of Managers who have the final say on the go ahead in getting full time people. We do have some who feel the hospital is getting along well enough as it is and we should not import someone else because it might influence my patient load, especially if he were really good or part time. But the vast majority of the staff have accepted our past imports. If we can't get new blood into the hospital all the time, something is wrong.

because everything that goes wrong is my fault. A couple of the surgeons, for example, think that I am the architect of the plan to get a chief of surgery. I know perfectly well that they don't want this. It's still a plum that they would like to be appointed head themselves. It really isn't. It isn't like it was in 1940 when the chief was considered the best doctor. That wasn't even right but that is what they thought. Actually a lot of people think that the chief of surgery now is the neurosurgeon because he is the busiest man on the staff. He is busy because he is good, he came when there were no other neurosurgeons and he made a tremendous effort to communicate with referring physicians.

It's an accomplished fact--it's been approved by the staff and by the governing board--that we can have a full time chief of surgery. One surgeon screamed and wanted us to reconsider, but we've heard the one surgeon's complaint and there is nothing more we can do about it.

I wasn't a revolutionist. I hide sometimes behind committees and work through the staff organization. I was no competitor of the other physicians on the staff. I also got 100% cooperation from the head of the department of medicine. Most of the other departments did. So I didn't have much trouble being accepted as a Director of Medical Education..

Two disappointed surgeons fussed about the idea of having a full time

I find that surgeons in other cities are opposed to having surgeons come in to take over the operation of the departments of surgery in their hospitals. The more people there are, the less work each one accomplishes. The interference with private practice which comes from having the department taken over this way is in the competition with a new person coming in. This wouldn't bother me but it would have some impact upon the department. Some surgeons already are not as busy as they would like to be. Surgeons should be skilled and dexterous in performing certain procedures but this can't be done on an intermittent basis. One person might not make so much difference, but a new director is likely to bring with him a number of friends.

A main question is who should pay for the head of a department. I have read how the per diem patient costs in teaching hospitals are the highest, the affiliated hospitals are in the middle, and the costs are the lowest in the community hospitals. I am not convinced in my own mind that the patient in the teaching institution is getting any better care, and perhaps not as good as our own.

Community Hospital Physician, Director of Medical Education Pre

Half of the people in this hospital are scared of me. That is a big bluff. I don't mean the medical staff but others. About two thirds of the medical staff hate my guts, the other one third doesn't care much and about three of them are pretty good buddies. They hate me

Footnote (1), to page 33

Community Hospital Physician, Surgeon Pre

If a strong and dynamic head of the Department of Surgery were appointed, he might orient the department toward some special interest of his own. This might rob the rest of the department of facilities that are badly needed. We need more space for emergency surgery. A lot of equipment in the coronary care unit has only limited usefulness.

We must establish a four year training program in general surgery or else our present program will be abolished. I don't know if we will need an affiliation for this. The main reason we were not accepted is that we were not unified enough as a department. Now we are trying to establish a stronger association of surgeons. A head of the department has now been authorized. Such a man however is not quick in coming. I have now been appointed administrative chief. There are three chiefs of surgery. One other just retired. We still have no director of the department as such. I will act as this until a full time person is found. I am opposed to the director of the department being paid by the hospital. There is already a group of full time employees at the hospital that I feel are not doing the job they should be doing. This includes the Anesthesiology Department and the Radiology Department. They can't put in a full day's work. The more help you get, the less work you get. Those who work hard resent this type of situation.

other departments. These seemed to be related more to the sense of threat an outsider might impose than to plans for improving the teaching program through more intensive use of local teaching talent. (1)

It was observed in the Department of Medicine that there were a number of physicians interested in education, but there was little evidence of their actually doing any "home work" in preparation for their teaching activities. Most physicians prefer to do bedside teaching in which interns, residents, or medical students have neatly summarized the important data and the teachers can extemporize upon what interests them. Although occasionally stimulating because of the virtuosity of some physician - educator, this does not necessarily give the learner a rounded understanding of what he needs to know in order to handle the widest variety of cases most efficiently. Education no less than other activities requires planning and preparation for it to be fully effective. (2)

The Department of Obstetrics and Gynecology got the best grades because, no doubt, of the special interest in medical education of the head of that department and the obligation imposed on each member of the department to participate in the educational program of the department in order to be admitted to the department. (3)

As can be surmized from the above, the Director of Medical Education,

Jefferson Medical Center Physician, Post

If you talk to physicians at the community hospital, they will direct the conversation into areas of strength. They will tell you what they know and not what they don't know. The patients may leave the hospital without the doctor knowing what the disease was. If one talks superficially, things can look awfully good. Sometimes however the treatment for a disease is as bad as the disease and one should know what the disease is. This may also lead to doubling the medical costs to the patient. There is a lot in life other than just going to the doctor. One of the patients I talked to didn't have a flush toilet but yet he had been in the hospital so often that he might otherwise have been able to buy one. Inadequate diagnosis and shotgun therapy cannot be defended because sometimes treatments may be very dangerous. Diagnostically one should try to get the information through the simplest procedure.

Footnote (2), to page 34

Community Hospital Physician, Director of Medical Education Pre

I had approached three medical school deans in the Philadelphia area with the problem of how much lag in information there is between the medical school and the practicing physician in the community. I had the idea to do exactly what Dr. _____ proposed. As far as I know the idea came out of my own head. I wanted to know what do we do differently, how far behind are we? You get this feeling if you are a little bit introspective and you go off to a national meeting and they are all having the same problem so you are reassured for a while. I think that one of the best ways to see that medicine is practiced well and that there isn't any delay--there isn't a whole lot when you go back and look at it--the fellows who have come back here have brought some ideas back but from what they have said, we're not so far behind, and in some ways we might be ahead of them. But you wonder about it. I've never checked any of this with a medical school. I don't think I pointed out any area, even to myself where there might be a lag. It could be anywhere. Genetic diseases are the current rage and Dr. _____ helped us a lot with this. The deans I talked to thought it was a good idea but they didn't have the money, the time, or the personnel. When Dr. _____ walked in with this idea, it was something I had been looking for for four or five years and it was really an answer to a maiden's prayer. I think I also used the expression that if he found skeletons in our closet, I'd be glad to know what they were.

might be interested. On both occasions the medical director said no. Neither of the established leaders in the hospital were willing to go for anything. For seven years there was no evident change in the hospital. Then they were approached with this program. We suddenly find that people are asking questions up there. Therefore there must be latent leadership up there as well.

Footnote (1), to page 34

Community Hospital Physician, Obstetrician Pre

Disinterest in one's department will often result in one's burying oneself in one's practice unnecessarily and leads to avoiding conferences, this goes back to the personality of the leader. Someone who is liked will attract members of the department to meetings and to teaching. Today, however, department heads really need special training in the psychology of how to get along with others and overcome inertia. This is a thought I just had now.

Jefferson Medical Center Physician, Post

Some hospitals do have distribution of teaching obligations. Something had to happen to each of these hospitals before a program could be set up. I suspect the motivation of hospitals participating with us in our continuing education programs is to enhance the ability of the hospital to attract house staff. We made it clear however that we were interested in practicing physicians and we were not about to take over their training of house officers. However, we pointed out that a program that was educational for one doctor might be educational for others as well. We pointed out that if they had good educational programs, they would attract people who are interested in good educational programs. When this hospital was approached, their reply was that they were not interested in 1960. It was contacted twice subsequently to see if there was a change of heart and if they

who was the alter-ego for the Medical Director showed very little genuine interest in or understanding of the way to develop outstanding educational programs at his hospital. (1) His involvement in the Exchange Program was clearly related to his desire to justify the quality of medical care given at the hospital, or, at least available at the hospital, and where glaring defects might be found, to correct these. (2)

The Medical Director/Director of Medical Education was prepared to acknowledge that not all patients at the hospital with coronary disorders, for example, might receive "ideal" treatment, but the opportunity for such was available in the presence of good cardiologists. Provided that there were no gross defects, the policy might be described as "hands-off." He asserted that the practice of medicine in this country was "still free" and that there was no way in which physicians could be forced to get consultations or to make referrals merely because they might not be up-to-date. By having some good or excellent facilities available for those who wanted to use them, like having educational conferences available for those interested in attending them, he seemed to feel that he had discharged his responsibility and that he would not then be the subject of criticism.

The Exchange Program was not apparently perceived therefore by the Medical Director/DME as a means of educating all of his staff, and especially, those who needed it the most. This was consistent with his

Footnote (2), to page 35

Community Hospital Physician, Director of Medical Education Pre

I think the medical profession is more guilty than other professions of hiding its mistakes. Medicine is not exact. Physicians only have circumstantial evidence in diagnosing and treating patients; he doesn't have confirmatory evidence. The public can't quite understand this.

Also physicians fear criticizing other physicians if they make mistakes because they are afraid they may be criticized sometime too.

A physician just goes on his experience and he has to be satisfied if he is 85 or 90% right.

I still practice. In the beginning I was on ward service. I still see a few consultations.

Footnote (1), to page 35

Community Hospital Physician, Director of Medical Education Pre

I get all the complaints about members of my staff. The people come in and tell me they don't like the way a certain doctor took care of them. Some of them are quite good and their complaints are well justified. When I get a justified complaint, I talk to the doctor. I never come out and tell the patient that something is wrong. I tell them I will discuss it with the doctor. Usually it is a misunderstanding and they go back and talk to the patient. This may have some effect on their own continuing medical education.

Community Hospital Physician, Director of Medical Education Post

If a physician attended the daily medical conferences, it is inconceivable that he would not learn enough to be a good physician and up to date. The ones who need this are not the ones who get it. With grown up mature people, one should not have to go out and use motivational techniques to get them in. What should be done is to remove physicians from the staff who do not participate in the programs, but this requires "guts" and I am not sure if we are ready to take such stern measures at this hospital.

general educational policy which was to leave the responsibility for educational activities to the individual department or service heads. He himself (see below P.6, #2) dismissed the job of the Director of Medical Education as requiring only five minutes daily attention. It is also interesting to note that he summarized his educational psychology in an equally simplistic fashion saying that people learn only as a result of punishment and that praise meant nothing, especially to "mature" physicians. Even here, however, he was observed to be very inconsistent punishing few and praising at inappropriate times. Offenders in terms of performance errors were rarely chastised. (1) In this context, the Medical Director/Director of Medical Education's comments may have self-referential value. (2)

Although it is frequently stated that the Director of Medical Education should be a strong, dynamic individual within the community hospital, this is frequently not the case. Often he is an individual who has become disenchanted for one reason or another with the medical school and does not wish to practice. He withdraws to a community hospital where he can relax. He may be an older physician approaching retirement who no longer has the energy available for full time active practice. Rarely are Directors of Medical Education trained in the field of education. Consequently, they do not usually think in terms of setting up objectives which can be defined and of programs through which objectives can be achieved or of means by which to evaluate the effectiveness of their programs. In most cases therefore, the main activity of the Director of Medical Education is simply that of recruiting house

Footnote (3), to page 36

Community Hospital Physician, Surgeon Post

All surgical procedures carried on here are in effect reviewed. This may be something that can be done in the community hospital. We have never had a strict surgical audit although we have had a tissue audit. There has never been a review of the necessity of surgery. Every now and then a hospital does need a boost in the arm. Some years ago we had clinical rounds in which the actual patient was brought to the conference. This was discontinued for various reasons. About 60% of the patients seen in the hospital are surgical patients. The medical audit we have in the hospital only covers gross errors. It is very definitely a useful procedure in the community hospital.

Footnote (2), to page 36

Community Hospital Physician, Surgeon Pre

Reports from the medical audit committee go to the Medical Director and he, if it is a flagrant violant, sends it to the executive committee. Otherwise he informs the individual he is the educating agent. He makes recommendations. Truthfully I do not think there was any attempt to go back six months later and see if there was any effect of the educational activity. Nothing formal was done to see if that individual was still having the problem.

The chairman of the medical records committee is a general practitioner. This position has been held by specialists in the past but this does not work because they have to depend on others for referrals. The Medical Director did not crack the whip in getting the house staff to complete the medical reports.

Footnote (1), to page 36

Community Hospital Physician, Director of Medical Education Pre

I came here as a Director of Medical Education in 1954. There weren't many at that time. I found it interesting. There was stimulation in meeting new people each year. I became Medical Director in 1960.

They had wanted a Director of Medical Education but I'm not sure they know what it was. They had a Medical Director's leg man and they called him a resident physician. I was satisfied that at least someone wanted a Director of Medical Education. I accepted the position with the idea that I wouldn't stay. The only idea I had of a Director of Medical Education was what I thought it would be. I'm not sure that a Director of Medical Education is a full time position. I think also that in a hospital this size, there is a need for full time chiefs of services and this may obviate the need for a Director of Medical Education. We certainly couldn't pay a man to coordinate a program; he could do that between eight and five minutes after. There are lots of them who write up all sorts of things but this is hogwash.

staff and seeing to it that they are kept busy.

In the community hospital in which this project was conducted, as indicated above, the Medical Director and the Director of Medical Education were one and the same person. Although this might mean that education could be given a prominent role in the hospital, the reverse is also true. In fact, the Medical Director's first assignment at the community hospital was as Director of Medical Education. The hospital had no previous experience with men in this position and he had no experience in that position either or knowledge of what the role involved. When he assumed the position of Medical Director, he kept his former title as well expressing his feeling that the position was not really very important after all. (1)

The presence of a medical audit committee did not guarantee that effective corrective action would follow the identification of physician practice not in conformity with the highest standards. A member of the committee commented upon its work as follows: (2)

In the Department of Surgery, things were even looser as indicated by this statement made by the Head of that department. (3)

Footnote (3), to page 37

Community Hospital Physician, Director of Medical Education Pre

The house staff doesn't get much criticism of their case presentations because you almost get to the point with house officers that you are afraid to say anything to them, for fear that they will write somebody at their medical school and you'll get even less of them. We attack the attending staff more vicoferously.

Footnote (2), to page 37

Jefferson Medical Center Physician, Post

I saw the worst case presentation I have seen in my life given by a resident at the community hospital. The resident was poorly prepared and poorly organized. He left out a lot of important material. After the sessions, however, the Medical Director walked over and told the resident how good it was. Other staff people indicated their agreement with me. This would never happen if the people in charge of the training program were doing their job and observing their responsibilities towards medical education. It would not have to come from an outsider. Third year medical students at the medical college do a much better job. Certain of the staff are apparently not satisfied now because of the exchange program.

Footnote (1) to page 37

Community Hospital Physician, Director of Medical Education Pre

I think I felt uncomfortable in medical school because of the freedom we had and the feeling that everybody else was doing so much better than I was. Fundamentally I think that I am sort of an incompetent sort of a soul, or I don't have much faith in my own decisions. I would walk around and I would get upset by my buddies talking about things and I would go home and think that I don't know as much about that. I don't understand as much as they do. There was a tremendous amount of freedom to do what you wanted to do. Nobody told me what to do. I still lack the self-assurance that some of my confreres have but I think I've done fairly well with what I've decided to do. One thing I have learned is to make up your mind and go ahead and do it. I think I've matured. I think it is due to my personality that I have been like this.

See also Footnote #1, page 33, item 2

The standards of practice found in this kind of a situation would be expected to be variable and personalized. Although the Medical Director/Director of Medical Education projected himself as a "bug-bear", apart from his somewhat gruff exterior he appeared inwardly to be insecure and unsure of himself as he himself recognized. (1)

He also rationalized that it was better to keep a physician whose medical performance was known to be marginal on the staff in order that there be at least some control over him rather than to turn him completely loose upon the community. In effect, therefore, in spite of his talk of "punishment", there was little or none. On the other hand, he was observed to be lavish in praise of case presentations of medical residents which were judged to be exceedingly poor by a faculty observer. (2) This use of inappropriate praise by the Medical Director/Director of Medical Education may be explained also in terms of his insecurity, this time in his relations with his house staff. (3)

Inappropriate praise is likely to be as disruptive as excessive or inappropriate punishment. Failure to provide good learning opportunities through good supervision by members of the attending staff of the work of the house staff cannot be remedied in this way. It is reasonable to suppose therefore that the poverty of the educational program as a whole was what was responsible for the decline in house staff experienced by the hospital. Interns and residents are most likely to be

motivated to go to hospitals for training where they will get the best training and the best supervision. The "grape-vine" information passed from interns and others to medical students is usually related to this. Being assigned "responsibility" by physicians who are too busy to give adequate supervision is not an acceptable alternative to most house staff. This community hospital was therefore already in the vicious cycle of physicians with excessive patient demands being made upon them thus making them unable to offer adequate educational opportunity to the hospital's house staff, the hospital being unable to attract sufficient house staff, the number of physicians in the community tending to decline, the patient demand upon remaining physicians increasing. The solution offered by physicians at the community hospital interested in preserving house staff training programs was not to give more of themselves, but in effect to give less by hiring full time physicians in selected departments who would take up the administrative chores and much of the actual teaching responsibilities. This may also explain the interest of many on the staff of the hospital in affiliating with a medical school; no doubt they perceived such an affiliation as a means whereby not only house staff could be increased and guaranteed, but they themselves would be given outside assistance in their teaching chores. If affiliation with a medical school were perceived as likely to reduce the income of the community hospital physicians to that of the medical school faculty, feelings would no doubt be quite different.

Community Hospital Physician, Internist Post

I feel an intern trained in the community hospital would be equal to one trained at the medical college. He will see many patients, he will have contact with physicians interested in the patient's problems; the majority are happy to sit down and discuss a case. The intern must then go to the library and do work on his own. If he will do this, he will end up as good as one trained here. The word around is that if an individual wants a residency at the medical college, his chances are better if he interns here. I suppose the individual who has his residency here would receive superior training. This is because he is in contact with more prominent men in given fields. These men may have better ability to teach.

Footnote (1), to page 39

Community Hospital Physician, Director of Medical Education Pre

I thought that a medical school hospital would offer me a better training as an intern. On a broad spectrum I still think this is so. But there aren't enough university hospitals to take care of all of the graduates, and I think that for those individuals who want to go out and practice in a community with a minimum amount of postgraduate training, I think they can do as well here, if not better than in the University hospital. Our house staff gets more responsibility than yours does. He probably gets as good an educational experience from the practicing physician. Our one year man gets more than in a university hospital. This is true in most good community hospitals. In the university hospital the intern gets less responsibility but probably better supervision because they have a full resident staff.

Community Hospital Physician, Director of Medical Education Post

Frankly, I think the intern does better here than he does at the medical school. The resident does better there than he does here. The intern is a sort of a man without a country down there. He's not necessary. The residents are exposed to experts who spend all of their time in one field. The people down there have a tremendous amount of time. There is no pressure on them.

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Thus, although the community hospital physicians and the Medical Director/ Director of Medical Education did in fact cooperate with the medical school in the Exchange Program, their motivation for doing so appeared to be mixed, there was never observed any "reaching out", any attempt to take the initiative, any flow of suggestions for new activities, any revitalization of old activities in the educational sphere at the community hospital which would reflect deep or intense commitment to medical education there.

Nevertheless, the physicians at the community hospital tended to justify their training programs, at least at the intern level, as the equivalent of those offered at the medical school. They did so, not on the basis of instruction or supervision given, but on the basis of the responsibility given to the intern. It will be noted, however, that the general feeling was that at the resident level, one does better at the medical college. The explanation for this is that the resident needs sub-specialty experts available to him that the intern does not. Of course, if one carried the thinking through to its logical conclusion, medical students might do well to be trained by general practitioners and nurses. (1)

It is noted that there is a tendency to accept the limitations in training of young physicians at the community hospital as a fixed fact of nature which is not subject to change. Among the considerations here of course are financial and economic factors. Because it may not be economically feasible at this moment for the community hospital to

is a good experience. The training here and at the community hospital would be similar except that the academic atmosphere here, conference participation and research projects, may make a difference. But I think it is a waste of time to have residents write papers. But I feel a lot of the research work not done by residents is also a waste of time. If a resident devotes this much time to a research project, he is neglecting other aspects of his training. Much of the writing particularly done by residents contributes very little to the knowledge of general surgery. The residents also spend more time studying and doing book work here. This esoteric type of thing to some degree may make the individual a more competent surgeon. The individual here is getting a better training. At the time of my training, the university trained surgeon got a broader knowledge than I did. They may be training a different type of surgeon in the community hospital. This idea of superiority of training residents was not generated here, it only strengthened an idea I already had.

Footnote (2), to page 40

Community Hospital Physician, Surgeon Pre

I had some unusual cases of intestinal obstruction and I published a paper about it. It was satisfying to prepare the paper. If I had the opportunity I would do it again. There are plenty of interesting cases. It is more a question of time than anything else. There is very little done at my hospital. There are some studies done for our conference, most of the men are too busy to spend the time, in any kind of research. I'm a younger man and my practice isn't as big as some of the others.

Community Hospital Physician, Director of Medical Education Pre

Exposure to research activities sharpens a man's thinking processes. It's similar to the type of thinking you do in studying individual patients. In a community hospital if they have some research to do, they should do it, otherwise they shouldn't. There is a lot of opportunity for clinical research here. Time is the biggest problem. Ob-gyn has done better than anybody else in this. The residents might do something. This is arguing against the things I said five minutes ago about the training of a resident.

Community Hospital Physician, Surgeon Post

The training that the resident surgeons receive here is adequate, it

Jefferson Medical Center Physician, Pre

A man worth his salt would not want to spend his life just doing the ordinary types of activities. If he has any gumption or an inquiring mind he likes to be titillated by challenges and that is why people come to attend my conferences.

It is now a daily occurrence for us to pick up radio signals from patients and to hook this up to a digital computer. We also have to give basic training in television to our residents. This can, for example, allow determination of whether a drug given to a cancer patient will be helpful to him or not. It allows getting immediate answers. These things will eventually be done regularly in community hospitals. We have to train people to do the type of thinking needed for the future. The curve of new technology in radiology is taking off. All of the electronic spin-off is coming into this department. You have images and you can take definite data from the images.

Jefferson Medical Center Physician, Post

How can a young man be stimulated if he does not see the future in the present around him? Sending their radiologist here will not do much because he will go back to the old environment. He needs to feel that he can apply what he learns when he returns. We can't develop our role until we know what these people are willing to do.

Footnote (1), to page 40

Community Hospital Physician, Surgeon Pre

My philosophy is to get the fellow cured as quickly as possible and back to supporting his family. This is the primary objective of the community hospital. We should not make tremendous efforts to do dramatic things when only 50 miles away there are numerous facilities to take care of the patient at no additional cost. I am afraid of initial expenses on equipment that in three or four years will be obsolete.

Community Hospital Physician, Surgeon Post

Residents at the community hospital get no training in vascular and cardiac surgery. I would be an opponent of open heart surgery now at the community hospital largely on an economic basis.

Community Hospital Physician, Director of Medical Education Pre

High speed computers will increase the rate of change of medical knowledge in the future. Now we use them only for business purposes.

When I went into medicine it was one of the most challenging occupations. I'm not sure that there aren't many more challenging now. The space, electronics, and other programs are certainly drawing people away from medicine.

develop programs in renal dialysis or open heart surgery, residents who presumably will need to know an increasing amount about these topics in the future are denied the opportunity to learn. The list might be extended. Of course, it is possible for the more advanced technology to be presented to residents at the medical school although this does make for a kind of discontinuity in concept. What is lacking, however, is not just the technology but the inspiration which has led to getting the technology. Striking contrasts can be drawn between the attitudes of some of the medical college faculty in their thinking about these matters and the thinking of the community hospital physicians. It is hardly surprising then that residents will seek their training where men are thinking about the future as well as facing the problems of the present. (1)

This attitude is also reflected in relation to the role of research in a resident's training. The orientation of research, of course, is always towards the future. The medical college because of its commitment towards research is clearly oriented toward the future. The community hospital at best is attempting to keep up with the present. For all practical purposes there is no significant research done at the community hospital. (2)

I wasn't uncomfortable because of the other people. There were times when I was uncomfortable with myself. There were terms they were spouting like I never heard of them but I knew them at one time. Some of the questions the professors were asking these kids had me stumped and the kids were doing a fair job. But, of course, this is stuff they just read last week. It makes you feel uncomfortable with yourself. I don't think this is limited to general practitioners.

Footnote (3), to page 41.

Community Hospital Physicians
General Practitioners Speaking in Group Discussion

One doctor said he attended a hematological conference at a nearby hospital and the speaker gave a complex discussion of hematology. He felt that you really don't have to do this. You can make a therapeutic test. The result of this may confirm the diagnosis. "We're all practical guys and we need to have things presented in a practical way." "One should forget all of these hypothetical discussions related to a lot of theory."

Community Hospital Physician, Director of Medical Education Pre

The medical school graduate of today has a lot of information and familiarity with procedures that we didn't have when I graduated.

Community Hospital Physician, General Practitioner Post

It was nice to be back in a university setting after so long. It makes you realize how easy it is to get lost in the myriad of details of what you're doing. I discovered that they were throwing around some new terms that I wasn't quite familiar with, new tests and studies, and so forth. Some of these aren't needed at a community level and they are used for teaching purposes here. If they did these tests when I was in school, I forgot about it.

Footnote (2), to page 41

Community Hospital Physician, Surgeon Pre

I was recently in Boston where I took a three week refresher course in general surgery. This was my first such course since graduate school. This had been planned for several years and was possible because I belong to a partnership. I'm not sure how much I got out of the program there although I enjoyed it. I found differences in vascular surgery and open heart surgery.

Community Hospital Physician, Surgeon Post

I enjoyed my trip here. I observed operations, participated in rounds. I had a very busy week, particularly with the operating schedule. This was my first trip back here since I was a student. The only place I saw open heart surgery before was on my trip to Boston.

Community Hospital Physician, Director of Medical Education Post

Physicians have lost much of their prestige. Sometimes I feel somewhat awkward to be identified socially as one. I think one of the biggest gripes among community hospital physicians is that the medical school professors have the prestige. They are always growling and grumbling that the medical schools are doing this or that. They also complain about taking men away from the practice of medicine. They resent that the medical schools aren't teaching clinicians. They aren't sure what they are teaching. I know what they're teaching. But the average physician wonders why these people don't come here to the community hospital to enter general practice. They never go to find out. They don't want to be confused with the facts.

Footnote (1), to page 41

Community Hospital Physician, Director of Medical Education Post

Somebody has got to take care of the sick people in this country.

But the federal government by its grantsmanship has made it possible for a man to hang around the medical school diddling with something that may or may not be of any value for a long period of time and a relatively liveable income. Jefferson is not as bad as the University of Pennsylvania. I'm sure if you went down and shook the University of Pennsylvania, you would find enough people so that there wouldn't be any doctor shortage in the state. I'm not sure that all of them are doing something important. Some of the medical college faculty lamented to me that they wish they could do more in the training of doctors who would then take care of sick people. I think that people in training should decide what they want to do in this regard. House officers who want to be practicing physicians should go away from the research and academic atmosphere. When I went to medical school, the most impressive people were the ones who looked after patients. The image today is more towards the researcher. They know all about microbiology of disease but not how to treat it. Every resident and clinician should do research but somebody has got to go out and take care of the sick. Jefferson has always had a reputation for training physicians who practice but they have gotten away from it a little.

Feelings as expressed by some of the community hospital physicians suggest even some degree of hostility towards research because of their own loss of prestige and because of the notion that research activities keep men not only from practicing medicine but even from being able to practice it. (1)

Being immersed in the present, some of the teaching faculty from the community hospital were literally not in contact with the present. The head of the department of surgery, for example, had only recently been exposed for the first time in his life to open-heart surgery even though any medical school student will have had some direct acquaintance with this technique for years. (2)

It was thus possible for there to be recognition on the part of the community hospital physicians that there was change in medical knowledge and that today's medical school graduates had access to this information which they themselves did not have, but to reject this as belonging somehow to esoterica. (3)

As practicing physicians concerned with practical matters, there is considerable justification for giving greatest attention to information of immediate value in terms of treating patients. However, in the competition for medical school graduates whose inquisitive appetites

Footnote (1), to page 42

Community Hospital Physician, Surgeon Pre

I am chairman of our Continuing Medical Education Program at the community hospital. I was given this job because I was interested in it. I keep up through our program, even though it is only a year old, and reading the journals. We invite the doctors from the other hospitals to come to our programs but not many have come. There is no area organization for discussing our common problems. The director of medical education happens to be on our committee with four or five other men from other departments. This committee was created probably because of discussions of interested individuals, involving perhaps, inadequacies or deficiencies in thinking and practice in the hospital. We really had to give many of them a boost. It was approved by our directing staff unanimously. Those who really need it perhaps are the ones who haven't responded. They are mostly in the realm of general practice.

have been whetted by the example of their medical college atmosphere, this practicality is of limited appeal. The community hospital physicians were clearly more concerned with their roles as physicians than as educators and they were more concerned with discovering the kinds of answers that were being given in the medical school by the faculty there than with the kinds of questions which were being asked.

Communication within the community hospital, therefore, within the educational context was judged to be limited and of uneven quality, not related to well perceived goals and purposes. An apparent exception to this was the monthly series of didactic lectures started coincidentally with the beginning of the Exchange Program. Insofar as there was about a two year period of preliminary discussions before the Exchange Program was actually funded and began operation, it is reasonable to assume that this series was motivated in large measure as a device to impress visitors with the fact that there really was interest in continuing medical education at the community hospital. There was also set up a Planning Committee for Continuing Medical Education which had as its only function the selection of eight speakers to come at monthly intervals to the community hospital to deliver the didactic lectures. (1) There was no attempt at all, as subsequent events made very clear, to coordinate these lectures with any other educational

value. It may be good for the general practitioners to get at least some exposure but it hardly meets their needs.

Footnote (2), to page 43

Community Hospital Physician, Surgeon Pre

The other hospitals in this community have continuing medical education programs with visiting teachers and professors but it is not quite as active as ours. Our programs have made an impact. I have heard quite a number of favorable comments.

Community Hospital Physician, Pediatrician Pre

We have the monthly lecture program, but three hours once a month isn't very much. But with the cost of this, we can't afford to do this more often. I don't know what the budget is for our educational activities. I don't know if it's secret or not. I have absolutely no idea what a reasonable figure should be. The physicians pay for this ourselves every year. There is also a grant from a drug company. It must cost \$4,000 or \$5,000 a year.

Jefferson Medical Center Physician, Post

The monthly program there is a lectureship gimmick. It is not very effective for most people. Well known people are invited in straight forward approach to education through lecture. There is nothing wrong with this if it is used as bait to get people involved in more active programs. The best place for educational activities is in their own conferences. A good turnout for monthly speakers does not mean anything. Participation in ward rounds and conferences may have some

Footnote (1), to page 43

Community Hospital Physician, Surgeon Pre

I think our program has been very worthwhile. The interest in attending shows there are people who want to learn. People come who do not otherwise come. They sit and listen. Some ask questions. I would say there were some results in treatment practice already at the community hospital. But we have no way of evaluating the effects of the program.

I would like to see more people in attendance at CME programs. We get about 50 people at our programs. Some feel the programs are unrelated to their field. Some are too specialized but I get something out of all of them. One can always get something out of anything.

activities at the hospital or to relate them to physician needs in any meaningful way. There was not even any record of attendance kept by name at these lectures. Speakers selected tended to be nationally known figures whose presence at the community hospital could add prestige without interfering in any way with any on going activities at the community hospital. There is no evidence of any formal evaluation being given to the program nor to any thought with regard to the meaningfulness of such evaluation in the first place.. (1) Insofar as most such didactic programs are known to be educationally ineffective, there is no reason to suppose that this program achieved anything of consequence apart from attracting the general-practitioner group in fair numbers. Although this is interesting insofar as it indicates that there is indeed some basis for communication with this group and the rest of the hospital, it seems only to be in relation to programs which cannot possibly threaten or offend anyone in which there is no fear of having one's lack of knowledge unfavorably exposed. (2)

It is noted, for example, in this regard, that the distinguished visitors presenting these lectures were given no opportunity to make rounds or to see patients. In part this may be related to the fact that the committee delegated with selecting these speakers had no other functions, and did not and was not expected to coordinate its activities with any other hospital group. Under such conditions, duplication of effort was

Footnote (1), to page 44

Community Hospital Physician, Surgeon Post

The trend among general practitioners is that their relation with the hospital is almost non-existent. Our continuing medical education program at the community hospital has been supported more by the general practitioners than by the specialists, by about 75%. Perhaps some of these individuals we suspect are not too interested, are more interested than we thought.

Community Hospital Physician, Director of Medical Education Pre

All three hospitals in this community have something going on that's called continuing medical education. We get a fair turnout. Actually however there is something going on daily on this hospital. Somehow the out of town expert has greater drawing power than home grown talent.

inevitable and was in fact observed to occur. The Medical Director/Director of Medical Education, moreover, tended to compartmentalize activities so that he did not perceive that what was being done in one area such as continuing medical education, for example, was relevant in some way to the training of residents and also to what was going on in the medical audit committee and was also related to the regular medical staff conferences. It was even observed that information about educational offerings to the residents, for example, might be purposefully not disclosed to staff physicians who might have been very much interested in it. As the individual who filtered all information relating to education within the community hospital, the Medical Director/Director of Medical Education thus was potentially the major obstacle to effective communication there.

Nevertheless, insofar as the hospital had some success in attracting some physicians to the didactic sessions who were not observed to attend any other sessions it appears that given more effort to communicate from above, response from below might occur. (1) A major communications defect thus seems to exist in the organization of the community hospital itself whereby ill-defined and poorly understood functions are entrusted to a single individual who works either alone or with committees who have no broad sense of purpose and who do not pursue the ramifications of what they are doing with regard to the overall

Footnote (1), to page 45

Community Hospital Physician, Surgeon Pre

To my knowledge, the medical audit has never lead to an educational conference, for example, on the use of antibiotics. It has been mentioned in staff meetings but has not been the subject of a formal discussion.

educational activities in the hospital. It would therefore occur neither to the continuing medical education committee or to the medical audit committee to study whether there was some relation between their interests. Both would report to the Medical Director/Director of Medical Education who failed to coordinate their various activities. (1)

It is not unlikely therefore that attendance at the didactic sessions will decline as the novelty wears off and as no attempt is made to relate these programs to physician needs or interests on a broad basis. On the other hand, it is reasonable to imagine that the budget which has been made available for these programs and the energy of the physicians on the planning committee which has set them up could be more usefully integrated into a more comprehensive continuing medical education program.

The medical conferences held by each major department at the community hospital, however, of course, were concerned both with the education of the house staff and of the attending staff. It has been observed that they are very deficient in terms of providing house staff with comprehensive and up-to-date medical information due to the lack of planning of those responsible for these programs in most cases. They are also deficient in terms of providing attending staff with information they also may need. The reasons for this relate both to the quality

because I have two associates. I used this as part of my vacation.

It's not that much of a burden but it is a burden.

conferences. We would hope more would come for visiting physicians but unfortunately they don't come. I don't think there has been any outside effect (the small teaching group interested in interns and residents). . . Aside from them most could not care less. They have sort of gotten out of contact with the profession and current medicine. They can make a living going as they are. If they can do this, they feel it is good enough. Of course, this is not right. Even attending our own conferences we put on, you always come away with the feeling that this is a session worth attending. I think it is related to how you start out in medicine. If you become heavily involved in everyday types of care, you don't have this much time to devote to further education. After a while it becomes difficult to force yourself. They will go to the AMA meetings primarily to get out of town for a few days.

Community Hospital Physician, Pediatrician Post

You get the impression that you don't want to hurry these people all the time. They have all these commitments. It's certainly a shame that there are people at the community hospital who are reluctant to come here because we have so much to gain. I've had a very enjoyable week. I've gone to courses but never participated in rounds. I would love to come down on my day off but I spend the day with my family. It's difficult. It takes an hour to come down. I could come down

Footnote (2), to page 46

Community Hospital Physician, Director of Medical Education Pre

The people you send to us do not have anywhere near the demands on their time that the staff here does. They also don't make anywhere near the money, they aren't as financially successful but they are more successful in what satisfied them. It's gotten so bad now that I think there might be some deficiency in patient care. I know that it has hurt our house staff training program. It's always the same way; the good teachers are the busiest practitioners and there are more demands on their time. These are the people who have gone to Jefferson on the Exchange Program. I have asked a couple of family doctors and they have not been able to find the time.

Community Hospital Physician, Internist Pre

I think the individuals who are putting themselves out a bit to cooperate in the enterprise are very well pleased with it. I think they like the idea. Those of us who have made an effort to see the doctors you have sent up to us have enjoyed their contacts very much. This is something that is very helpful. Our problem is that the percent we can get to take an active interest in this is not what you might hope it to be. We would like all of the staff to participate but not all the staff will do this. It's the same group at our teaching

world. The hospital is used as a place to put patients in and it may not be looked on as a teaching institution. In fact, anybody can make this what they want to make it. The point is that when you get to the community hospital, people are on their own. It takes a lot of discipline to take the responsibility to prepare conferences. If general practitioners were to come to our conference, they would improve it but you need the people to give the conference and this we don't get.

Jefferson Medical Center Physician, Post

The conferences are not badly attended in the sense that they could generate a discussion. About 15 people allow a good discussion. The conference should be an educational experience for all people present even though they may not realize it as such. The reason they don't get a large attendance is that the quality of the programs doesn't conform to what they would get here or at medical meetings. They don't talk glowingly about their own activities because they don't put enough into their programs. At only one conference was the radiologist present and he did show up with films, but he gave the impression of not being oriented as to what aspect he should present. Not a single general practitioner was seen in the conferences.

Footnote (1), to page 46

Community Hospital Physician, Surgeon Pre

Our conferences are important but they aren't the answer as far as teaching is concerned. We have surgical grand rounds and tumor conference. There is probably too little participation and interest in those attending. The discussion generally is between a very small group of individuals all the time. They may feel the others can't express themselves as well, they may be a little bashful. There has been no effort to overcome this. Conference attendance generally includes the same people.

Community Hospital Physician, Pediatrician Pre

I didn't get to attend any of the conferences involving the Jefferson faculty. In private practice up there you are so cramped for time, it becomes impossible. Most of the pediatricians have the same problem. We make our rounds early because we have to go out to see sick babies. We have weekly pediatrics conferences usually but since we don't have interns this year, we haven't had them.

Community Hospital Physician, Pediatrician Post

When Dr. ____ was in our community hospital, we had a special pediatrics conference every morning. Everybody knew about it in the hospital. Yet, only five people showed up. Each of us has our own little

of the programs and to the lack of interest or time of the attending staff, especially the physicians in general practice. (1)

The major defense used in explaining the failure of physicians to attend hospital medical staff conferences is that they have insufficient time to do so. This is usually related to the great pressure on the physicians to care for patients. (2) Although there is no question but that physicians at the community hospital are busy, the explanation is not compelling. Had the physicians in the community been concerned in the past with their continuing medical education, had they transformed their hospital from a purely service-oriented institution into a truly educational institution, as has happened in some communities, the hospital would have been so attractive to potential house staff that they would never have had to go for an entire year without interns nor would they face discontinuation of their residency programs in any field. Moreover, enough of the trainees would have remained in the community to handle patient demands although it is likely that the reputation of the institution would have generated patient demand from a much broader geographical region. Were they to do these things now, things would soon be different. The pressure of time generated by patient demands in the present situation at the community hospital may therefore be interpreted as much the effect of the limited attention given to developing the educational program at the community hospital

Footnote (4), to page 47

Community Hospital Physician, General Practitioner Pre

There could be worthwhile programs at the community hospital to bring some of the older general practitioners up to date if you could get them interested, but I am not sure if you could get everyone interested. I have thought about this but I have not come up with a good answer. If I saw stagnation coming on me, I would then specialize. The general practitioners in my hospital as a group are doing nothing. It might be worthwhile to try to organize them. Continuing medical education programs geared to the general practitioner might be a first step in such organization.

Community Hospital Physician, Surgeon Post

The opportunities are there for everyone to learn. If they don't want to, that's their problem.

Footnote (3), to page 47

Community Hospital Physician, Pediatrician Pre

I'm not aware of any thorough examination of what the opportunities might be for making the programs more interesting.

I'm sure there are many things we could do to get more participation. I think it is due to inertia that has set in. These are things you talk about but you're so busy you never get to do anything about them.

Community Hospital Physician, Internist Pre

I don't feel that feelings of discomfort in itself would be enough to keep the general practitioner from attending anything we put on. The last thing the doctors in our department would want to do would be to embarrass physicians who attend our sessions. We should make things as attractive and rewarding as we can. We have never done any studies to find out what has attracted men to our meetings or kept them away. There isn't anything very obscure about our sessions. At one time we changed the time of our conference to be a half hour later but there was no difference in who attended. After a few months we went back to our regular hour. Those who do attend are those who do live in a closer relation to the hospital. After some time when we get our office building, this will make some difference on attendance.

Jefferson Medical Center Physician, Post

Some of the general practitioners concerned about the large number of patients they have to see. In part this is their own fault. They don't do any weeding among their patients. It is just a waste of their time to treat head colds. The easiest way to handle people coming in with trivial illnesses is to raise the fee a little. If they cut down a little on their work load, they could get into what is exciting about their kind of practice. If they want to have the role of quarterback, that is diagnostician on the medical football team, they have to get in and learn all of the plays.

If allied health science people could be used more, the physician could devote more time to the people with more complicated illnesses.

same office. Now all of the family doctors and most of the specialists are asking for help.

Jefferson Medical Center Physician, Pre

In smaller community hospitals where the men are overworked, they have no time or energy left over to sit down for their continuing education. The demands of the public give them no time to do the studying they might want to do. Studying takes time and you have to have a clear mind. You can't do this when you are at the phone with numerous interruptions. The problem of medical education is not that of not wanting to do it but it is the social-economic pressures. Doctors who have to overextend themselves will not live as long. The responsibility for the doctor to take time out to study goes beyond the individual doctor. Group practice is the key to giving physicians more time. Any physician would be willing to dilute his income up to a point. However, because the public makes the demands, the public has a responsibility to make it possible for him to study. The physician should be in a position to go out and forget his busy chores from time to time. Individual physicians should be able to decide whether they learn best by attending classes or reading by themselves. The impediment to group practice may be that of tradition. It was started here as solo practice but this was not necessarily so strong in other parts of the country.

remember ten years ago fights in the medical society here about the hospital absconding with the practice of medicine in the accident dispensary, treating a doctor's patients and not giving them back to him. This takes a load off the doctor's shoulders but in another way, I think he still resents it. The progress of concentrating the practice of medicine around the hospital is nation wide and it is here.

The physician has been notoriously slow to give up a lot of the things that it is not really necessary for him to do. Maybe it could come down to the actual history and physical examination. In the Second World War they took a lot of average people and made hospital corpsmen out of them in a very short time. They were very efficient. In another year and a half of training in North Carolina they have made them into doctor's helpers. You can train a technician to help a surgeon in the operating room better than an intern can do. Some of the doctors here are talking about these things. In ten years from now there will be satellite groups out in these smaller places. There will be family practitioners and there will be specialists in with them too. It will be covered seven days a week 24 hours a day. Some lesser trained person will handle the house call.

Solo practice is going to disappear too. I'm afraid again that this area is far behind other areas in that. It's only been ten years that the first group of physicians that I can think of had even two in the

Footnote (2), to page 47

Community Hospital Physician, General Practitioner Pre

I disagree with most general practitioner's. They all claim they don't have enough time. There is if you make it. If you want to practice medicine, you practice it good and not by halves. Our patients may be backed up for two or two and one half hours. It may take a half hour to find out what is really bothering the patient. They are too embarrassed to tell their ministers. I'm psychiatrically oriented. We do the histories and physicals for psychiatrists and you get to recognize the patterns. The psychiatrists don't do it because of time and they are awfully afraid they'll miss something. The psychiatrists are swamped. Sometimes we are so busy we think we've reached the limit of what we can do and then you just go on.

Community Hospital Physician, Director of Medical Education Pre

Having an office building for physicians here at the community hospital would be the most important thing to help solve the time problem. It should have been done 40 years ago when it was first suggested. 40 years ago the objection was that the independent practitioner of medicine didn't want to have his office owned by a hospital. There was also professional jealousy with doctors in the other hospitals. This community is a little more conservative than the average. I can

Community Hospital Physician, Surgeon Pre

We have a four man practice. Otherwise there are only a couple of two man practices in this community in surgery. I could not possibly do any more than I am doing now. That is why we have to get new men. I was doing two or three emergencies every night. I was not getting my rest. Then I started goofing off and not taking care of my patients properly. There were complaints from patients and doctors. The only other choice was to get some help. Our group has been functioning for five years. The men in my practice can do whatever they want. If the hospital doesn't object, I don't care.

Footnote (1), to page 47

Jefferson Medical Center Physician, Pre

20 years ago there was no shortage as far as house staff was concerned. There is no general shortage even now of physicians in the area. There may be a shortage of general practitioners to some degree, but there are also a number of general practitioners who are not doing very much work. This group is not necessarily older. They want more time for leisure; this is a voluntary restriction.

Community Hospital Physician, General Practitioner Pre

Each year it gets worse as far as having enough general practitioners in this area. I went into general practice because I am an idealist. Even in high school I had the idea that medicine was treating anything that "comes down the pike" I always admired my own doctor. I am perturbed by people having to be referred to doctors for various different things. General practice is what you want to make it. A lot of general practitioners are unhappy because they don't take enough time to practice the way they want to. This is their own fault. If you have to sit down and read for two hours, do it. As long as you feel you can handle it, it is a challenge. Time is your worst enemy and this interferes with a lot of people doing this. Although I am new in practice, there has never been a time when I could just sit down and play bridge. But if you want to do it (i.e., read) you can find the time no matter how busy you are.

as its cause. (1)

There has not been any study of physician utilization of his time at the community hospital, but a number of physicians suggested that it was rather inefficiently organized. Physicians treated patients who shouldn't have been patients at all; physicians attempted to be individualistic in their practice of medicine when this was no longer possible; physicians failed to make use of trained allied health service personnel who could relieve them of much of their pressure; physicians failed to have their offices located geographically near the hospital in order to be there more frequently. (2)

Although recognizing that attendance at conferences was generally poor or limited to the same small group, no actions have been taken by the community hospital physicians to discover why physicians fail to attend. (3)

In general the tendency is to relegate failure to attend conferences and other educational activities simply to disinterest. (4) (F. P.1, #4, item 2) (F. P.2, #2, item 3)

Assigning lack of motivation however may not always be the correct explanation for behavior which fails to conform to one's anticipation. Another reasonable explanation implied by a Jefferson faculty visitor is the lack of two-way communication between the different groups in the hospital, that is, between the teaching and the non-teaching group.

The specialties are greatly overemphasized. I would like some kind of a preceptorship in order to help the attitudes of medical students towards general practitioners. Some of the general practitioners are not interested in this program. This applies more to the older general practitioners who may not have been keeping up.

Footnote (3), to page 48

Community Hospital Physicians
General Practitioners Speaking in Group Discussion

One doctor said he attended the meeting because he had a specific "bitch." He had been in general practice for 20 years. "I feel I am representing the vanishing buffalo part of the practice of medicine. I am a specialist in treating sick kids and the pediatrician is a specialist in treating well kids." "This gives you a belligerent attitude and an inferior outlook." "At the University they look with disgust on the general practitioner." "I wonder if the attitude of the medical school is not responsible for the attitude of the public." "The people we treat are often more difficult to treat than their diseases; the specialists have lost sight of this because they only treat part of the patient." "The incentive to go into general practice is not being stimulated in medical school." "The status of the general practitioner according to everyone's belief is that he goes into practice because he does not have the time or is in a financial bind."

Community Hospital Physician, General Practitioner Pre

Some physicians (general practitioners) are afraid to come here for a week because they think they may be looked down upon in meeting high powered specialists. This stems back to medical school itself.

Footnote (2), to page 48

Community Hospital Physicians
General Practitioners Speaking in Group Discussions

When asked what they don't get at their conferences at the community hospital, one doctor said that they are concerned with the whole patient but he can't get a specialist to talk about a whole patient.

it did not have sufficient support. Some interpreted it as a gripe session.

General practitioners are somewhat lost in the hospital and nobody knows what to do with them. Each is an individual running his own practice, seeing his own patients. The question is whether general practice will die and have to be revived or whether it can be saved.

Community Hospital Physician, General Practitioner Pre

It's not too late to organize a department of general practice in my hospital. But I don't know just what we would do.

Jefferson Medical Center Physician, Post

There has to be communications upwards, which is taken to heart and is respected if a program is to work. If things are imposed from above, it will take a generation.

Jefferson Medical Center Physician, Post

The coffee shop discussions were mostly concerned with superficial matters such as golfing but there were some medical matters discussed. I was steered into the coffee shop to the same group by the medical director. This happened three times. On the third time, I went to the table where the general practitioners sit in their own little group at a separate table. In order to discuss between generalists and specialists, one would have to leave his table. The general practitioners could profit by attending meetings.

Community Hospital Physicians
General Practitioners Speaking in Group Discussion

The reason there is no general practitioner organization in the community hospital is because there are 40 GP's who are all very individualistic; there is too much variation physically and mentally for them to get together. This type of group was attempted before but

Footnote (1), to page 48

Community Hospital Physician, General Practitioner Pre

People coming here would be beaten down not by the people here but by themselves. This is because of the gross inferiority complex of general practitioners. It is not true on a community level that they are uncomfortable in working with specialists. Lack of status does not explain the failure of the general practitioners to participate and to attend conferences in the community hospital. There is some tendency there however to defer to the older senior specialists.

Community Hospital Physician, General Practitioner Post

If I can continue my education one way or another on a community level without organization, I don't care if it is organized or not but I don't think that is possible. There definitely has to be organization on some level. I don't know what the answer is. If you organize the general practice people you are working on a status level. Now the GP's can go to the department of medicine meeting but they don't have any real say about who might come and give a talk or other things. Because of this problem, community medicine or family practice will need two or three additional years. People will no longer be called general practitioners.

The latter is in a less prestigious position and avenues for communication are limited by the lack of organization in this group which could promote such communication. (1)

In part there is communication difficulty between the specialists and the generalists because to some extent they do not speak the same language and have not attempted to learn each other's language. (2)

With only a few exceptions, the general practitioners at the community hospital form a group apart from the rest of the attending staff. They are differentiated not only in their not generally being identified with any specific hospital department (though they are at times thought of as belonging to the department of medicine) and in their not having participated in any formal training in a residency program, but in terms of their general status at the hospital. Although effectively a group apart, they have no voice of their own. They themselves tend to be somewhat defensive about their position in the hospital, in the community, and in the medical world generally. (3) They apparently fear being excluded from the hospital and disappearing from the medical scene as fewer and fewer medical school graduates choose general practice. As a rule they do not participate in the medical conferences and they are also only infrequently observed in the library. This apparently is a result of their perception of themselves as somehow being outsiders

and to some extent they are also made to feel this way.

It was noted, for example, that the non-verbal communication between the Medical Director/Director of Medical Education and the general practitioners was very different from his communication with the rest of the staff. When consecutive meetings were held with one group and representatives from the medical school and then with the other group, it was observed that the medical director sat among the specialists and in general insinuated himself into their company as "one of the boys" as it were. However, when meeting with the general practitioners, he sat apart from them and seemed to lecture them in a somewhat paternal tone.

Two tables are set aside for physicians at the coffee shop in the community hospital. Although much of the conversation over the coffee table is not related to medicine, much of it is and it is not unlikely that more information is exchanged there of value to physicians than at the formal conferences. One of these tables, however, was unofficially designated for the specialist physicians and the other for the generalists. There are no signs indicating this but the segregation is real nonetheless. This kind of caste status arrangement of course works to the detriment of communication flowing freely among all physicians. It is not unlikely that some tangible changes could be achieved

in terms of improving professional communication at the community hospital merely by having these two tables consolidated into a single table or using some other device to break up the existing pattern.

The isolation of general practitioners at the community hospital seems to be rooted in multiple practices and attitudes. The main result of this is simply that the general practitioners are not active in the educational programs at the community hospital in contrast to some of the specialists. General practitioners, for example, rarely are members of the medical audit committee. The Medical Director/Director of Medical Education defends this saying that at least in the medical audit the patient should have the advantage of the best physician knowledge. It is much more frequent that general practitioners will not be asked to participate in the teaching program at the community hospital even though such activity would probably do most to change their attitudes towards their own continuing medical education and to induce them to participate more actively in the medical conferences, etc. Because they do not participate in the teaching program at the community hospital, most of the general practitioners do not have house-staff coverage for their patients. Nevertheless, when there were no interns at the hospital, they were asked to participate in giving the hospital physician coverage. This led to overt expressions of resentment as men were being asked to participate in chores from which they perceived that they would get no benefit in return.

Footnote (1), to page 51

Community Hospital Physician, General Practitioner Pre

If it ever got to the point where I would act as a sorter, I would then go into a specialty. The need will never disappear but I don't know if general practitioners will in fact disappear.

Community Hospital Physician, General Practitioner Pre

I don't think there are going to be any general practitioners left in 15 years. I think maybe it will be a good thing if regional medical centers are in existence at that time. Most kids want a small world where they know their limits exactly and won't make any mistakes. This would be a large group practice with the sorting being done largely by the patient. But general practitioners are useful now. People want a doctor who knows everything about the ten kids in a family. It makes a lot of difference to the patient. Eventually the community hospital will be composed of hospital based physicians in all specialties. They're turning into a medical center with salaries paid. General practitioners will be of no use except as a sorter. At that time it will be a closed staff with no GP's on the staff and I will no longer be a general practitioner. They think they can give better care to the patients. I don't agree, but when I lose my inpatient privileges, I will no longer be a general practitioner. We will have departments organized just like the medical schools.

A rough division of general practitioners is into the "older" and the "younger" groups. The older men are seen as somehow beyond the pale. This is consistent with observations in the Pennsylvania physician licensure data suggesting that older men participate less frequently in programs of continuing medical education. Some feel as a consequence that very little effort should be expended to try to attract these older men to be active in hospital educational affairs. It is felt that they are too wrapped up in their outside activities to be willing to participate in the first place. Secondly, it is felt that they have little to offer. Somewhat different attitudes are held with regard to the younger general practitioners. They seem more interested in their continuing medical education and are also interested in teaching at the hospital but even with them there is the fear and expectation that general practice may pass out of existence and some of the younger men have their eyes on possible residency training programs which they may eventually enter in order to qualify for stepping up to a specialty. (1)

The general practitioners thus appear not only to feel and to some extent to be isolated from the mainstream of medical communication at the community hospital, but to be unstable and defensive about their status. They would like to believe that help is on the way and that the medical schools will suddenly start propagandizing for graduates to go into general practice. But they recognize that as the medical schools adopt "core curriculums" the very small percentage of young men

Footnote (1), to page 52

Community Hospital Physicians
General Practitioners Speaking in Group Discussion

Dr. ____ asked if there were any areas in which the medical school could be of help to the general practitioners. He asked if there should be a survey to find out what areas they needed help in. He suggested however that programs should not be "directed" at general practitioners by downgrading them. This is intellectually insulting and not really very worthwhile. However, because they have cut out a larger field than others, they need to be exposed to more educational programs than others. They need the same knowledge as others and they need a broader spectrum of knowledge.

Some indicated that they were not willing to give up a whole week out of the office for something they might not derive much out of, and that we in the medical school would get almost nothing out of them.

going into general practice is likely to continue to decrease.

Oddly enough, the one thing that might save general practice is not recognized or is avoided. It is conceivable that through an active ingestion of the educational offerings at the community hospital, the general practitioners could keep up with enough of the developments in modern medicine to justify their continued existence. (1) As the Medical Director/Director of Medical Education asserts, it is inconceivable that any doctor could attend the daily conferences and not learn. However, it is the general practitioners who are most lax about such participation. The specialists who, in some ways, at least, need continuing education the least, are the ones who are most likely to partake of it the most.

It is reasonable to assume that special motivation is needed to make a man want to be a general practitioner, especially in this age of specialization, excluding those individuals who are obliged to go into practice as soon as possible after graduation in order to support their families and to pay off sometimes large debts built up in the course of their medical school education. In discussion with the two general practitioners who participated in this exchange, the following were raised as possible attractions to this form of medical practice:

Footnote (2), to page 53

Community Hospital Physician, General Practitioner Pre

I like people. The look in the eyes of people I treat is enough to sustain me. It has to do with why I went into medicine. My father wanted me to go into medicine and I couldn't care less. He had wanted to be a doctor. In my junior year I found it was more important than I thought because I didn't get the support of my school. They told me I would never be a doctor. I suddenly discovered that being a doctor meant a lot to me. If anybody gives me a challenge, stand back because I'll try.

I'm kind of an idealist. I guess that's why I became a general practitioner. But in medical school I feel somebody along the line forgot to teach me compassion. I have found that mistakes I have made in giving the wrong injection, writing the wrong prescription, and by errors in judgement were heftified by the compassion I had shown before. When I blew the ball game, there were no repercussions whatsoever. People accepted the risk of the game. When I came out of medical school I kept looking at diseases rather than at people who had diseases. It just doesn't work out that way. Cold indifference probably won't affect your medical efficiency but as a general practitioner I have to have rapport. Sometimes I use a big man, a gifted man who doesn't give much attention before or after the operation. The residents give most of the attention.

Footnote (1), to page 53

Community Hospital Physician, General Practitioner Pre

The general practitioner does not live up to his own job classification of being fully accessible, but he can if he wants to.

1. The general practitioner wants to feel that he is available for any person who "comes down the pike."
2. The general practitioner wants to feel that he is able to treat the whole patient and not just some limited portion of him.
3. The general practitioner wants to be able to be available to the patient at any time and not just during office hours or in the hospital.

These three interests may be summarized in terms of an overall desire to be available or accessible. (1) One might infer from this the desire for the general practitioner to be bigger than himself in the service of mankind. (2) The general practitioners are not unlikely to project themselves as altruistic and service oriented in contrast with the specialists they project as being prompted by less worthy and less noble aspirations. As one practitioner stated, "The general practitioner treats sick babies; the pediatrician treats well babies." Many of the general practitioners were apparently inspired by the kindly family doctor with horse and buggy who forms an important part of American Folklore.

It is striking to note, however, that in spite of the desire to be available and accessible to all people, at all times, for almost anything medical, there is a strong tendency for the general practitioner to limit his availability and accessibility in all of the areas mentioned. He is less and less willing to accept all the patients who come to him. He feels obliged to refer an ever larger number and to seek consultants who take over his more difficult cases. Many general practitioners

Footnote (3). to page 54.

Community Hospital Physician, Pediatrician Pre

About half of the children are seen by general practitioners. There is no particular pattern of selection as to whom is seen by a pediatrician or a GP? Some people just want a family doctor. For any single isolated illness, it makes little difference. For total care, I think we in pediatrics have more to offer. The GP is geared to take care of acute illnesses. They are less likely to see the behavioral problems.

Community Hospital Physician, Physical Therapist Pre

Some of the physicians at our hospital are well read and widely read. I think the general practitioners are less likely to be widely read. They are terrific workers with night hours.

Footnote (2), to page 54

Community Hospital Physician, General Practitioner Pre

I was so tired after the Navy, I didn't think I could stand another three or four years of schooling. I knew specialists too who were unhappy. When I looked at the city where I practice, I found much to my surprise that the majority of specialists were general practitioners first, and went into a specialty later. I thought I might do the same. I kept this as an ulterior motive if I got sick or overworked.

Community Hospital Physicians
General Practitioners in Group Discussion

Most general practitioners are interested in getting more factual knowledge about diseases and also in learning about psychosocial problems. They don't like indefinite or vague programs. When the person from the medical school approached things in a program so that physicians felt they already knew the basic problems, there was a better attitude toward what is being learned. Most programs run for general practitioners are a total waste of time. They want to be brought up to date about things they already know about. They object to being taught as if they never heard of the basic ideas. The speaker often doesn't understand the problem of the general practitioners. If a physician, for example, sees 105 patients a day, he couldn't possibly culture that many sore throats.

Footnote (1), to page 54

Community Hospital Physician, General Practitioner Pre

To the patient, it means if they have a general practitioner, if they have problems, they can discuss them with him. Patients are very much in favor of general practitioners. The majority of patients like to say that they have a family doctor, someone they can call if there is sickness in the middle of the night. It is possible, however, to train your patients so you don't have unnecessary housecalls. About 10 to 15% of patients need counsel from the general practitioner. About 50% need some guidance if you consider everything. The main problems relate to whom is running around with whom. Women are often disturbed by the peculiar sex habits of their husbands. I am different from most general practitioners because I worked my way through eight years of college. I don't usually charge for the 20 minutes or half hour discussions with individual patients. I am sympathetic with them on the subject of money because of that. The general practitioner may be disappearing because he no longer serves the unique function he was set up to serve. He may have lost some of the emotional satisfaction he gets from being a general practitioner. They get into problems time wise and they don't keep up and this leads to dissatisfaction. They end up treating mostly sniffles in the office.

are thus beginning to perceive themselves as "sorting stations" for patients whom they send to one specialist or another. They may no longer even make the diagnosis except in a superficial sense. Moreover, although the general practitioner professes interest in the kind of comprehensive medicine that treats the entire patient, the essential ingredient for this kind of practice is that there be sufficient time available to do it. Comprehensive medicine cannot be hurried medicine. However, some of the general practitioners in the community hospital are reported to see as many as 90 or 100 patients a day. With such a heavy work load, they hardly have the time to do the thorough kind of work-up which treating the whole person demands. (1) Finally, the general practitioners, like other physicians and like professional and subprofessional men of all kinds, are less and less available for house calls, night calls, etc.

The net effect of this is that if one assumes men are indeed attracted to general practice in hopes of achieving emotional gratification based upon the need and desire to be available and accessible as described above, they are likely instead to experience increasing frustration. (2) Moreover, to the extent that their work load interferes with their continued learning, the quality of medicine they practice is likely to suffer. (3) Their ability to recognize the source of their frustration and their defensiveness about the quality of their practice may.

Footnote (2), to page 55

Community Hospital Physician, General Practitioner Post

I think it is a mistake that you don't know what they are presenting at a conference until you get there. If you knew what it was, you could do a little reading. This they don't do.

In a community hospital, there are not so many interesting cases and this makes it harder to schedule in advance because an interesting case may just have come in the day before the conference. I don't know if you can get around this.

Jefferson Medical Physician, Post

I found no discussion of the recent journals. They could have their own journal club but they don't.

Footnote (1), to page 55

Community Hospital Physician, General Practitioner Post

I don't think that my thoughts about the role of the general practitioner in the community hospital are any different than when I came down here. I still feel there is a definite need for continuing education. I would like to see the general practitioners in the community hospital area organize themselves, to bring more programs into use.

encourage them to project their negative feelings onto their specialist peers at the community hospital and onto the ivory-tower physicians at the medical schools. Medical conferences at the community hospital may be perceived as an unnecessary waste of time and of interest only to specialists who have nothing else to do but talk. Medical school physicians may be resented for their picayune research activities. Comments to this effect were expressed by some of the physicians interviewed.

In the long run, it seems reasonably clear that the demand for high quality medical care by the consumer will force the less well trained and less up to date physician out of the market. Even though there is a physician shortage on a national basis at this time, sufficient competition can be generated to oblige inadequately trained physicians to accept additional medical education. The place for this education no doubt lies in the community hospital. Identification of educational need through identification of deficiencies in medical practice may become the lever of change. Whether general practice in this community will then survive will depend upon how general practitioners respond to the challenge and how effective an educational campaign the community hospital can mount involving them. (1)

Communications defects were also observed even in quite prosaic and obvious aspects of the communications system at the hospital. (2)

an hour or two but instead of doing this he will call in a consultant who presumably has the information available. The tendency then is to take what the consultant says hook line and sinker and not really be critical of it. Some of the ob-gyn people said it was a new awareness on their part. This is probably still limited to a small minority of the better leading physicians. This has probably not filtered down.

Footnote (2), to page 56

Community Hospital Physician, Internist Pre

If an individual who has not been keeping up is confronted with a sticky problem, he either does not do it well and the patient suffers or else he unloads the patient on someone in a given field. It is far better for the patient. Often a consultation is sought from a specialist but it is difficult for the consultant to do what is best for the patient because the patient has not been transferred. After expressing his opinion the specialist is supposed to sign off. It is not to the patient's best interests. What you do for the patient today might not be what you would do tomorrow; the condition is not static. There may be follow-up in the snack bar after a couple of days but this is not the best.

Community Hospital Physician, Director of Medical Education Pre

We have a very high consultation rate in this hospital. When two men see a patient, I don't think there are too many major errors.

Jefferson Medical Center Physician, Post

There is already a high rate of use of consultants at the community hospital. Frequently in a busy institution, a physician runs into a problem he could sort out by going to the library and studying for

Footnote (1), to page 56

Community Hospital Physician, Physical Therapist Pre

We have an amputee clinic that about a dozen nursing students attend with some of their faculty. Occasionally we have sessions with some of the residents and interns. When we have an especially interesting case, we just page to have some of the men come down. You have to moreorless go on the highways and bi-ways and compel them to come. If they come, they are happy they came but they are busy.

Interested individuals at the community hospital such as the physical therapist whose background prior to coming to the community hospital and whose dedication in life was to testing the possibility of setting up physical therapy schools independent from medical colleges, reported making use of coercive measures successfully but apparently irregularly in attracting physicians to his own conferences. (1)

Apart from the conferences and physicians' rounds at the community hospital, there are a variety of communications channels there through which physicians make contact with one another and the outside medical world. Because the hospital is small, there is a quality of intimacy in the relations among the physicians of its staff which does not necessarily hold among the faculty, for example, of the medical college. This permits communication in various formal and less formal ways. The most obvious of these is in patient referral and in consultation. Reports from the physicians indicate, however, that there is likely to be rather great variability in the extent to which these techniques successfully achieve physician education. In fact, it is possible for the referral or consultation to provide the physician with a means of avoiding learning. Consultant suggestions also may either be uncritically accepted or as uncritically rejected. (2)

It may also be noted that patients are referred from "below" to "above." This means that they will be referred from general practitioners to

Footnote (2), to page 57

Community Hospital Physician, Surgeon Post

This program may have an effect on those other than just the ones who participate in it, because we're naturally going to talk about it but I haven't heard too much discussion. Men talk more in their own specialty areas.

Jefferson Medical Center Physician, Post

I found a fair amount of communication within groups within the hospital. There is a lot of advice given within these groups but I'm not sure there is much outside of these groups.*

Footnote (1), to page 57

Community Hospital Physician, General Practitioner Pre

I know my limit. I get a hunch. I'll call up a specialist. I can keep up because I limit myself. We dropped ob-gyn. We got into a hassle with the hospital about it. I may drop minor surgery but I enjoy it. If I have complicated psychiatric cases, I'll send them to a psychiatrist. We like acute illness like everyone else does. I don't know how I'm different from an internist. You can get vest pocket consultations from specialists; they'll talk to you about a patient but won't charge you anything. I'll talk to them in the halls. In this way I keep up. It doesn't sound like much but it means alot to me.

Community Hospital Physician, Internist Post

I personally always felt that whenever I had an opportunity in the community hospital, I certainly did not mind passing on medical information I happened to have to a doctor who calls on me for it.

Part of my duty is not only to the patient, but also part of my job is to educate the doctor who has not had the opportunity to keep upon this disease to the extent that I have.

specialists or from one specialist to a sub-specialist. A general practitioner does not refer patients to other general practitioners and it is also quite unlikely for specialists to refer patients to general practitioners. Referrals are often made with very little background information being given to the new physician. The patient may return after treatment with little data about what has been done for him. Although some physicians make it a point to follow up their patients when they refer them to other physicians, this is not a general policy. General practitioners who make such referrals are likely to be too busy to be interested in any feedback of information except what is absolutely necessary to handle the case. They are also likely to limit their cases to those which are less complicated and less time consuming and they are not unlikely to trade on informational tid-bits handed out by the specialist which may be expected often to be greatly simplified and watered down. (1)

Doctors at the community hospital are likely to establish relatively close relations within small informal groups to the exclusion of individuals outside these groups so that referrals are made within a somewhat circumscribed context. This means that such information exchange as there is will tend to take place within these closed groups. (2)

There is also a very strong tendency for the general practitioners simply to refer any patient who has need of hospital treatment to a specialist

Footnote (3), to page 58

Community Hospital Physician, Surgeon Pre

Someone who does not have to rely on referrals can be more authoritative as a head of a department in getting work done and in handling disciplinary matters. There is a need for impartial authority; someone outside the hospital would be better.

Footnote (2), to page 58

Community Hospital Physician, Internist Pre

I think you have to go ahead with your knowledge or else you go backwards. There isn't such a thing as standing still. You have to become a bit more knowledgeable or else you become less in contact with the situation. I believe an individual can lose contact now with medicine faster than he could have 25 years ago. You have to keep at the current advancements even to understand the terminology and have some degree of basic understanding of what it is all about. If you have been out of contact with current literature, you have to take time to orient yourself right. You can lose contact faster. If an individual is to keep professional respectability, he has to work harder at it now than 25 years ago. If you could take a doctor who was out of contact for 15 years and put him into this kind of environment, either he is not interested in medicine or he will very rapidly start to absorb what's going around him. In the hospital environment he is saturated. He will begin to become aware of his limitations and he will start to read on his own. Getting the physician into the hospital and holding him there for a while, assigning the doctors night coverage in the hospital helps to reestablish their contact. There's more in the hospital that goes on than meets the eye. Being there for 12 hours or so is an educational step.

Footnote (1), to page 58

Community Hospital Physician, Surgeon Pre

Some of our GP's do not take care of any patients in the hospital. This is in the past year. This is because they are too busy and can not handle their patients in the hospital time wise. Inadequacies probably still exist in spite of this. Inadequacies are both in diagnostics and therapeutics. Certain men just don't take the time to get to the basis of the problem. If you see 100 people a day, it can't be done. I might see ten to twenty people in my office in an evening. I have ten and twenty people in the hospital at one time.

Community Hospital Physician, General Practitioner Pre

It is 100% true that the general practitioners, especially the older ones, have isolated themselves from the hospital. I know GP's who have given up hospital practice or who would not take on new patients.

and to avoid caring for patients in the hospital or even coming in the hospital for that matter. (1)

Absence from the hospital environment may have a negative implication with regard to a physician's general knowledge and competence. The failure of the hospital to attract interns as noted above led to assigning all physicians periods of night coverage at the hospital. At most during a calendar year this would amount to four or five such duty nights. Even so there was the feeling that this would have some impact upon the physicians involved. (2)

The specialists who get referrals from busy generalists have mixed feelings about this insofar as they feel that many of these cases are time consuming and might be handled adequately by a general practitioner who would be willing to do some extra work on his own. However, specialists depend upon referred patients to a large extent and they are likely to avoid criticism of their colleagues for fear of losing patients. The same fear impedes the work of a department head who must also depend upon patients for all or a major portion of his income. (3)

The one-way movement of patients for treatment from generalist to specialist therefore means that the generalists who presumably have the greatest need for medical information are not likely to get much of it through this means. Where the generalist has made mistakes, the physician

of medical centers. You read about it and you hear about it. If you don't one of your confreres might.

to me. On a typical week we have a conference starting at 8 o'clock lasting for an hour, three or four times a week. We also teach the nurses, nine hours a year. Besides this we will have county medical society meetings which is about two hours a month, a lecture program monthly at the hospital, and occasionally we meet with interns in the evening to discuss special topics. In the course of a month 25 to 30 hours would be a minimum of time I actually spend in conferences of this type. This would not include hours of reading plus talks with my associate. Two heads are often better than one and I can get a free consultation. The average physician in internal medicine in my community does not go to as many conferences as I do although some go to more. The average internist tries to keep up with his reading. One of my friends does not try to keep up with the literature but he waits until he gets a case and he will then go to the literature. This has merit. It is hard to keep up with the volume in all fields and this is hard on the brain. I'm reviewing this. I wonder if I'm doing the right thing. I try to save the most important articles which I file according to topics. This is a never ending struggle.

Community Hospital Physician, Director of Medical Education Post

I think you learn in your reading, in your care, and in your discussions among yourselves, especially the discussions between one and one's fellow physicians. I think that all of the new information comes out

Footnote (2), to page 59

Community Hospital. Physician, Internist Pre

In the hospital we have lectures, we have discussions, we have seminars, we have precepts, we have conferences with the house staff and other members of the staff. Some of this is didactic. I'm in the position of being in charge of endocrinology conferences at our hospital. Over the course of a year we try to cover the field of endocrinology as it might apply to the practicing physician. In this we are very vulnerable to questions, some of which we can't answer. Some questions are directed by the house staff, some by other physicians. We have a group of doctors in our hospital who are quite compatible and who are quite astute in picking each other's brain. We get friendly criticisms in a friendly light. We don't have too many personal animosities. This makes for a very good two way communication. Endocrinology is a small area and there are not many endocrinological problems which are still important. When we get into a situation where we don't know the answer, we have an excellent library and librarian. If it is not available in the literature we may seek help from elsewhere. We will often send patients from our hospital to the medical center in Philadelphia for special hormone assays or things we can't do here. I try to keep up by going to the American College of Physician's Meetings and regional heart meetings and so forth. For specific patient problems, it is a matter of time and I would much rather send a patient, and have the other doctor report

if you have the real desire. We don't have any control over them.
We were going to oblige weekly attendance at some conference. We
thought we might put this into the constitution.

practitioners; these are men who send in patients and occasionally take care of them. The second group is 45 and less. We come to Philadelphia. Dr. _____ and Dr. _____ are mentioned. They come here and to other medical schools. The younger men are much more inclined to keep up. If I weren't in partnership, I would close the practice for a week. It wouldn't bother me. It doesn't bother the other guys. I can understand the generation gap. These men came out in solo practice when we were the "king of the hill." This lasted for ten years. Now they see their prestige and practice is eroding away. According to them, their patients want to go to specialists. I came out specialization oriented and I'm willing to accept them. They refuse to see the pediatrician's existence; I use them but rarely. Some criticize pediatricians. Except for rare diseases a pediatrician has a general practice for children. I can take care of 95% of their cases as well as they can.

Community Hospital Physician, Internist Pre.

I believe the general practitioner is more likely not to keep up. I believe he gets out of contact with the hospital a little. He is not really of the hospital family. He could be. He is only there to check on his own patients. If he were in contact more with the hospital group he might find out more. I'm sure these individuals are very busy but I'm sure also that you can find time for many things

Footnote (1), to page 59

Community Hospital Physician, Surgeon Pre

I think it's true that there are differences in the way general practitioners and specialists practice, partly because the specialists are organized in terms of departments and the general practitioner does not fit in. General practitioners are likely to get in a routine of ordering drugs; I don't know why this is more so with them except we are more acutely aware of the indications and contra-indications. The general practitioner is interested in getting the patient well and he tries to do it quickly. He tends to study the patient somewhat less. Most general practitioners I know are overworked; most are busier than I am. They can't control their practice as far as patient's demands. They take short cuts. Instead of making evaluations of throat cultures, for example, they will give a shot of penicillin in the office and hope. I would not treat colds with antibiotics. I truthfully have never talked about this with physicians who might use antibiotics in treating colds. I feel they should have enough medical foresight to know the correct way of doing it.

Community Hospital Physician, General Practitioner Pre

From my observation of the general practitioners, there is a generation gap. Those of 50 years and beyond, it's 75-80% of the general

called in as a consultant or to whom the patient is referred is unlikely to "bite the hand that feeds him" and his advice is likely to be limited to what should be done at the moment with the patient rather than to review what might have been done in the past.

The generalists as well as the specialists at the community hospital who were interviewed on the exchange program invariably identified general practitioners, especially the older ones as deficient, the least up to date, the most likely to practice out-moded or inadequate medicine, and, of course, the least likely to participate in active communication within the hospital. (1)

In addition to these communications sources for physicians at the community hospital, there are a variety of very informal exchanges which occur between physicians in the corridor or coffee shop of the hospital, at the lunch table, at outside social meetings, in their group practice arrangements for those who have such and with physicians in and from other hospitals. Many physicians report these to be their most fruitful sources of information. (2)

The preference for physician to physician exchange of information is easily understood. It allows very practical information with regard to patient diagnosis and management to be exchanged with no responsibility being assumed for the advice given. Also, to the extent that

Footnote (1), to page 60

Community Hospital Physician, Surgeon Pre

I've been hearing about this program from different people who have been here because I was coming down and I wanted to get some idea about it. Otherwise there is little discussion unless you ask for it. Informally in the coffee shop there is more communication.

Community Hospital Physician, Pediatrician Pre

I talked to a number of doctors who came down here from the community hospital and they thoroughly enjoyed it. We didn't have any exchange of information about what is going on down here. It's in part because of the set up. We talk in the hall but pediatrics is in a corner of the hospital and we rarely see the other doctors. I'm sure this has been discussed in rounds I don't get to. So far I don't see any impact of the program on practice or attitudes. If there is anything, it will probably take a long period of time.

one is obliged to reveal one's ignorance of a given topic in order to get information about it, it is less likely to be painful in this limited exchange. However, for those physicians who actively do seek out contacts informally in this way, this may be the most potent source of information and new medical knowledge for them. The effectiveness of the technique, however, is difficult to document and is likely to vary in relation to different physicians.

Insofar as informal discussions generally involve no objective record of what has been discussed, the opportunity for misinterpretation of the information exchanged is greatly magnified. Moreover, as has been noted above, the informal contacts of physicians at the hospital tend to be restricted and to fall into clusters with little movement of ideas between groups except for special purposes. The physical arrangement of physicians tends by custom to put these groups together at the coffee shop, at the cafeteria, and, of course the physical layout of the hospital tends to keep each group of physicians separate. Cross-fertilization of one discipline with another is very limited. Moreover, as may be inferred from the comments about the general practitioners above, they are rarely seen in the hospital beyond the coffee shop and live in their own private worlds of professional practice with only a few exceptions. (1)

Small closed group information exchange of course may be expected to

interested would want to continue it.

Jefferson Medical Center Physician, Post

The effect of the Penn resident in surgery coming to the community hospital is good.

Footnote (2), to page 61

Community Hospital Physician, General Practitioner Post

I would very much like to see how to get the rest of the general practitioners more involved in continuing medical education programs at the community hospital, but I don't know how to go about doing it.

I don't know how you can change things to any great degree. As I see it, the only thing you can do is to bring in outside speakers and have conferences, and try to get more people interested. I think that it may be a progressive thing through the leaders. It has to be done at our level, maybe through upgrading conferences. The monthly program is well attended because they have interesting speakers and topics; they are interesting to everyone, not just a specific group.

Community Hospital Physician, Director of Medical Education Post

The people who have participated in this would like to see it continue. They think it is wonderful. The people who have been exposed to the visitors also think so. All of them admit that a year is too short. But they would want to know who is going to pay for it. There are both financial considerations and the problem of time because we are so short-handed. It would be easier to send residents or fellows. It wouldn't be possible to send staff men and let the residents cover their practice. If the financial part of it could be worked out, I think we could carry it on as it is. The leaders, the ones who are

partnership, if we can know of meetings ahead of time, it is easy to attend. This is an advantage of a partnership.

Footnote (1), to page 61.

Community Hospital Physician, Surgeon Pre

Some partnerships have not worked out due to personality clashes.

My group almost broke up once. We had professional guidance in setting up our group practice. We meet with them once a month. We justify this to the patients on the basis of offering them better service. Each member of the group goes away once a year for a week for some kind of post-graduate training.

Community Hospital Physician, Internist Pre

Doctors in all fields are clamoring for associates. We would like a third, fourth, and fifth man in our own group.

Community Hospital Physician, General Practitioner Pre

I have known my partner since college. We trade information with each other. But the majority of general practitioners are in solo practice. The trend may be changing. Younger people go into general practice with the idea of getting a partner right away, primarily for the time factor. Younger men do not like to go in with older men because they are afraid of being submerged and having to do the "scut" work.

Community Hospital Physician, General Practitioner Post

We have evening office hours every night except Wednesday. Being in

occur within the few group practice arrangements which have been set up in the area. Although there is some recent tendency to increase the number of such group arrangements, the traditions of the community in the field of medical practice run strongly counter to this and the great majority of physicians, especially of over-worked general practitioners continue in solo practice. (1)

The felt inadequacies of the internal communications system as means of bringing physicians into contact with what is going on in the rest of the medical world outside of their community is suggested by their special interest in having visitors from other areas, especially those who would be unlikely to threaten them in terms of their practice or their expertise. For this reason didactic lectureships of the sort described above are welcome. This also explains in part their interest in receiving residents in training from the academic world. (2)

The reverse of this, of course, is to have community hospital physicians go to the larger medical centers to refurnish their medical knowledge. Some of the community hospital physicians report fairly regular attendance at meetings in other academic institutions and some report annual pilgrimages to medical schools. There is no structure or organization to this exchange, however, and the purposes of the visits are likely either to be obscure or very personal. There is no evidence that such visitation actually produces significant changes in hospital practice except for a few especially dedicated men. It is also likely to become

Footnote (3), to page 62

Community Hospital Physician, Surgeon Pre

In some ways the house staff is educating the practicing physician by ordering various tests with which the practicing physician is not familiar.

to any group at all. I never noticed any particular concern of doctors. I'm sure those who realize what has been done wrongly are concerned.

Community Hospital Physician, Surgeon Post

If we had residents for four years, they should come here on rotation. Affiliation would be a source of supply of interns and residents for us. It would also be good to have a professor come one day a month to stimulate interest. It should work both ways and surgeons such as myself should continue to come here. It should not necessarily be funded but it should be out of interest. Asking a day a month is enough but a day a week is too much. We don't have a large enough surgical staff to send a person for a full week here every year. In so doing we might miss other meetings of interest to us. Perhaps about every three years would be desirable.

Footnote (2), to page 62

Community Hospital Physician, Internist Pre

In our medical world, it is sometimes difficult to stop and talk and think with your associates. Once in a while it is good to have a person of the magnitude of Dr. _____ to come and exchange ideas. You have to do this periodically. Medicine is changing so rapidly you can't take anything for granted. You must have this give and take of ideas.

Community Hospital Physician, Surgeon Pre

I think newer ideas are communicated by word of mouth at meetings. The personal experience of talking allows things to be discussed that can not be put on paper such as the little pit falls that are encountered. So far this kind of Exchange Program experience seems to be more efficient in permitting the introduction of new ideas. It also permits making contacts on the medical college staff so that you can channel problem cases to them. But I do not think this will produce any startling change. This type of contact is good because we are too small to have formal urology conferences.

Community Hospital Physician, Surgeon Pre

As far as life and death are concerned, the physicians' not keeping up to date is not too important. We do see problems that are due to lack of understanding and not keeping up with the times. This applies

are things that are new or new to me because we don't do them here. But I found out that what you are doing and what we are doing are similar, at least on the highest plane. We don't have, for example, as extensive an endocrinology laboratory as you do. Some of them were confirmatory for some patients but they didn't open the whole book. There were a few pearls dropped but you can't go to any medical school without that.

Jefferson Medical Center Physician, Post

I found one individual in the medical department who goes one day a week to the University of Pennsylvania. He conveys the newer ideas to the men at the community hospital. I found no one to do this in the surgical department. There is an advantage to having someone go up from here to there intermittently because this allows them to develop things in their own institution. This is preferable to having a chief from here take over the activities of any of their departments.

Community Hospital Physician, Internist Post

Last fall I went to the upstate medical center at Syracuse and I was impressed with their physical set up. They have more modern teaching equipment in terms of audio-visual equipment. I was there a week. It was a course in internal medicine. It consisted of clinics, conferences, and didactic lectures. A nice environment helps learning and it helps the institution to keep its personnel.

Footnote (1), to page 62

Community Hospital Physician, Surgeon Pre

I was looking forward to coming down. I contacted a lot of staff members during my residency but I was never here.

Community Hospital Physician, Surgeon Pre

Truthfully, it does not happen too often that anyone comes back from a medical meeting to make a report of the highlights of the visit at our conference and tell about the newer ideas. Offhand I can not remember where this did lead to some change in medical practice but I am sure there are some.

Community Hospital Physician, Director of Medical Education Pre

I've been offered a couple part time medical school appointments but the amount of time I can get away is too little. When I first came here, I went to Philadelphia about once a week. I make up my mind every fall to do it again but there is too much to interfere with it.

Community Hospital Physician, Director of Medical Education Post

I went back to John Hopkins for a week last year. Two years ago I was in New York and three years ago in Boston, at medical schools. My experience at Jefferson confirmed the fact that we're not this far behind. When you go off into laboratories, which I did not do, these

very irregular with the passage of time, especially if left to the individual's own initiative. (1)

It is difficult to avoid the conclusion that the physicians at the community hospital are so busy and so independent, that they fail to make adequate use of the communications opportunities available to them in their own midst. They look to the "visiting fireman" as a way of catching up on what they might have been doing continuously on their own. (2)

The role of the house staff in educating the physicians by stimulating the physicians to keep up as teachers has been discussed above. One physician suggested that the house staff may educate the attending staff more directly by showing acquaintance with tests the practicing physician would not be familiar with. (3)

In some ways the physical layout of the hospital and the somewhat reduced volume of patients seen there permitted more expeditious communication between the laboratory and the physicians than may be found in the medical school. The laboratory is perhaps one of the most important agencies at the hospital through which the physicians may be educated. There is no indication however that the laboratory personnel have ever systematically followed up physicians' usage of the information they have given to them and the suggestion obtained from an observer is that the physicians are exceedingly uncritical of laboratory findings. Presumably

Footnote (3), to page 63

Jefferson Medical Center Physician, Post

I have found no evidence of truly organized rounds. Residents wander in to Dr. ____ occasionally seeking advice.

Footnote (2), to page 63

Jefferson Medical Center Physician, Post

They do not have physician coverage 100% of the time in the coronary care unit. They make use of a "code" system when a physician is needed. On the one occasion while I was there when this was used, it did not work for a full half hour. On paper it looks well organized but in an actual crisis on this one occasion, it did not work.

Footnote (1), to page 63

Jefferson Medical Center Physician, Post

I was impressed that the patient might have an upper GI series done in the morning and the report would be on the chart in the afternoon. This is something we do not do. Their internal communications is very efficient. I saw the same thing with the pathology report, but they took a day or two. If this were not the case, there was something wrong.

Here there is a constant rush to get the answers. The doctors go to the X-ray department. Their surgeons read less of the films than they do here. Here nearly every film that is taken is looked at by the physician. Their physicians would not do this except where the report is abnormal. They don't follow up as much as we do in routine things.

also if a physician gets laboratory reports concerning tests with which he is not familiar, he is likely to ignore these and pay more attention to what he is familiar with. (1)

Looked at from a distance without attention to the details of how things function, the community hospital communications system does not appear to be gravely deficient. On paper, at least, all of the necessary components are there. The absence of general practitioners from contact with the mainstream of medical activity within the hospital is perhaps not too unusual or difficult to explain. The failure of the hospital, however, to maintain a steady flow of house staff, the failure of the teaching staff in many areas to provide adequate supervision for the house staff, and the tendency to solve problems by importation suggest that indeed not all is well. The overall situation may be likened to a specific instance observed wherein the paper organization guaranteed to meet any thinkable emergency in the coronary care unit simply failed to function, and in which the patient died. (2)

This reflects the tendency at this community hospital to be satisfied with paper descriptions of how things should work. (3) This tendency is most strikingly exemplified in the utilization of committees there. When a problem is recognized, as in most complex institutions, the usual mode of handling it is to set up a committee. Proper organization

requires that the leadership of the hospital delegate specific authority to the committee necessary to accomplish its task. This in turn requires that the committee be assigned a specific charge which will occupy it. Tasks assigned to committees should be "whole" in the sense that the committee can handle all aspects of what is involved within the charge given to it; failing in this, the committee should coordinate its activities with the activities of other committees concerned with related matters. The attitude of the Medical Director/Director of Medical Education towards committees, was openly hostile. He said at one point that community hospital physicians were simply too busy to work on committees and that committee work was ineffective anyway. He asserted that a "camel was a committee's design for a horse". Moreover, rather than delegating authority to others on committees, he managed to appoint himself as chairman to most committees he set up. This meant, in effect, that all decisions had to go through him as an individual and that if he chose to be inactive, nothing would be done. On the other hand, this meant that if he were disposed to act abruptly and hasten into unplotted areas with a minimum of coordination of effort with what was going on in related areas, this too would happen, sometimes with almost disastrous results. Having all committees made up of the same individuals nullifies the committee as a useful tool.

Poor actual organization where there is a reasonably good paper description

Footnote (2), to page 65

Jefferson Medical Center Physician, Post

They need more radiologists. Under their structure, however, they would have difficulty in getting more radiologists. Only the head of the department does the private patients. This does not make for a good feeling of mutuality. I would not consider it a happy department. There needs to be more confidence demonstrated by the chiefs towards those underneath.

Footnote (1), to page 65

Jefferson Medical Center Physician, Post

Graduate education cannot be piecemealed. It needs a full time director. All of the hospitals should be brought together. Consolidation of hospitals would be welcomed by the community hospital doctors.

They would have to give up some of their prerogatives.

of what is being done in an institution, often cannot be detected until serious failure appears. Sometimes, of course, identification of the inadequacy may be too late to salvage something of intrinsic value. To some extent this state of affairs may be condoned and even blessed by a dominant minority in an institution who perceive response to new situations with any change of structure as a threat to their own prerogatives. In the present situation the existing hospital structure is part of a community structure in which there are three hospitals and solution of the basic medical educational problems will eventually dictate that prerogatives are given up by many individuals in these institutions as well as by the institutions themselves. (1)

The underlying "malaise" therefore is a reasonably classic one in communications theory: Real Needs are not perceived by the decision makers. This leads to alienation of some members of the group from the rest of the group. Communications is likely to be one way, from top to bottom rather than two-way including from bottom to top. (2). Absence of formal or even informal evaluation of results of activities at the community hospital is a measure of this communications block.

The extent to which one wishes to introduce change must be a function of the level at which one wishes to work and this is likely to be a function of the total resources available to effect the desired change.

Footnote (1), to page 66

Jefferson Medical Center Physician Post

There is currently very little dialog in the area among the hospitals or with the local college. They have resources for their own continuing education that they don't realize and don't use. They were surprised by this and immediately grabbed onto it.

Noting that the manpower and financial resources available for change through the Exchange Program are inconsequential in relation to the financial and manpower resources of the attending staff at the community hospital, the approach has necessarily been limited and even cautious. However, the existing structure is not without its internal contradictions and this makes the possibility of meaningful change thinkable even with these limited resources. By working on a "one-to-one" basis with individual physicians judged to be reasonably highly motivated toward change of a rather undefined quality, specific changes might be effected in practice and outlook. Informal one-to-one contacts permit a maximum of practical information to be exchanged which is of direct and immediate value to the recipient with a minimum of threat being perceived in terms of his losing his practice, prestige, or having his inadequacies unfavorably exposed. This also permits the recipient to recognize his needs more freely and to think about alternatives. In this situation it is believed that the medical school may then be perceived as an ally in a virtuous cause. This is largely the level at which the Exchange Program was directed in its initial phases. On the other hand, if one wishes to get at "root causes", this approach is obviously slow and of limited effectiveness. As an initial step it may be necessary, but in order to meet the overall medical educational needs of physicians in a community, more elaborate and extensive two-way communication must be established and guided. (1) Because, for example,

the general practitioners at the community hospital have no formal department or organization through which they can communicate to one another or to the hospital administration, they are the least influential physicians at the hospital. Because there are no strong and somewhat independent committees grappling with problems of medical education, quality of medical care, and the future course of activities at the community hospital, very little is being done in these vital areas.

Overcoming the inertia found at deeper levels introduces new hazards and complications which are both challenging and potentially disruptive with regard to the changes which are sought. The communications system at the community hospital must therefore be thought of as having a structure and a dynamics of its own which must be understood for change to be accomplished. The extent to which this community hospital and this community are typical of others in the state and in the nation cannot be fully determined. The hospital is known to be different in some ways at the outset by reason of its earlier rejection of opportunity to develop continuing medical educational programs there in conjunction with the medical school. In any event, there now exists in some measure a picture of what is communicated, by whom and to whom, and for what purpose, at the community hospital studied in this Exchange Program.

Changes Brought About in Hospital Communication Patterns

As the preceding section shows, there are a multitude of communications activities in the hospital communications system. Some of these, especially those which are less accessible to direct inspection, are judged to be somewhat impervious to change. It is judged to be reasonably easy to have some impact upon the communications activities and continuing medical education of some physicians. Those who are eager to keep abreast of current medical knowledge, though relatively small in number, are easily identified in relation to their participation in the teaching program at the community hospital and attendance at medical staff conferences there. The organization of the community hospital especially in relation to the office and person of the Medical Director/Director of Medical Education, the traditions towards conservatism and independence of physicians in solo practice, the multiple fears of threat experienced by some physicians with regard to introducing changes to the established order of things, and the lack of a viable system of communication utilizing committees and delegated authority in assessing problems and recommending comprehensive solutions to them mitigate against change. Such change as occurred during the brief period of operation of this Exchange Program was therefore not across-the-board, but in selected areas only.

It should be noted that the Exchange Program tended to coincide with

me to refresh my mind on some basic signs in physical diagnosis. There are some things which are important that I must confess I sometimes overlook. You can never stop learning physical diagnosis because if you stop learning, you forget and go backwards. Being around doctors using their fingers and eyes to the utmost in physical diagnosis helps.

Community Hospital Physician, Internist Post

You can't impede the progress of medicine; as medicine gets more facts, it's impossible for a man to keep up in all of these fields; we need more and more specialists, our needs are not too dissimilar to those of a medical school.

I was impressed after being here a week that we are not doing things too badly. We're in the right league. In some areas perhaps we might need some learning. In general I think we are doing a good job of training our house officers and our staff. The conferences here are better attended because there are more doctors. There are more inter-departmental conferences which I like. I've been trying to push at the community hospital but so far we have not had enough. This is done more at a school with multidisciplinary teaching.

It's been a very interesting week. I feel I have learned some medicine this week. I may even have been able to contribute a few things. I almost felt like a member of the faculty. I had several lengthy discussions with the professor of medicine. I was able to glean some idea of what makes him tick. His efforts to get excellent men in the subspecialties is similar to the problem we have in a community hospital. We are large enough to want to have subspecialists too.

Rounds here are more on the grand scale. Our rounds are somewhat similar. We have the same bedside techniques but it was helpful to

of the personnel we need, not much in techniques. I didn't see any different techniques there than here. They use audio-visual aids much more than we do. There are lots of ideas that I would have to make this a better going concern. The first thing I would do if I could support it in some way is to have a man come, not for a week but for a month. It's easy for me to come because my salary keeps on coming, but the men in private practice lose more than you will pay in one day. Just as travel is broadening, I think it is important to have men come here and to have our men go to the medical school.

On the professor's rounds, I don't feel that the doctor there did any better than some of our better people would do. In endocrinology, the discussions were better because there were doctors there that we don't have a counterpart for. The same holds for the clinical research center. You are far ahead of us in places where we don't have anything.

There is no question that the quality of medical care in the medical college is better than the community hospital. This is because of the number of people who are seeing each and every patient. I said that I expected the quality of medicine to be better there and it was.

There are things at your place that can't hold a candle to what goes on here. The nursing care is far superior here. Cleanliness and housekeeping are better here. This is part of a hospital, but I guess not the most important part.

Footnote (1), to page 69

Community Hospital Physician, Director of Medical Education Pre

In the medical school hospital there are multiple people all interested in seeing patients--medical students, house officers, and attending physicians. If there is group practice and committee activity rather than an individual physician seeing a patient, the chances of a patient getting an accurate diagnosis and optimum therapy are better there than in a community hospital. If only 30% of our patients are seen by house officers and 100% of yours are, it would stand to reason that yours would do better. Secondly, you have consultant services that are the experts. I've talked at pretty good lengths to your men here already and I don't think my ideas will change much when I see your hospital. I found out the standard operating procedures pretty well. Except for nursing service, housekeeping and food, I have no qualms about the medical school hospital being better.

Community Hospital Physician, Director of Medical Education Post

In terms of the total amount of education and communication, you are far, far, far ahead of us. There is something going on there every five minutes. The discussion that was carried on was very good, but I didn't feel that much better than what we would have here. The educational message of this for the community hospital is that we need manpower capable of the subspecialty investigation. It's the caliber

the hospital's diminished ability to attract house staff. Whereas other hospitals with which the medical school had programs in continuing medical education had been able in large measure to meet their quotas of interns, this community hospital which had previously resisted developing its own continuing medical education program or one with the medical school suddenly found that it had no interns at all. Moreover, there was considerable bleakness in the outlook for residency training programs in several major departments in the hospital, notably the Department of Surgery which was about to lose accreditation for the limited training program it had conducted. The ground was therefore fertile in some respects for change. The Exchange Program might therefore serve as an effective catalyst. To some extent this appears to have happened. The Exchange Program provided a focus of attention for those physicians interested deeply in the future of medicine within their community suggesting to them the need for change. It gave them an opportunity to see what was happening in a major medical center and to think about their own community hospital and its needs. It stimulated considerable comparative thinking on their part; in general, the results of this introspection disclosed to them their inadequacies and this led some to think of ways in which to overcome these inadequacies. (1)

One of the most striking measures of the newly recognized need for change at the community hospital which was generated in large measure by the

their part, an unwillingness to give up some of their time. Normally this means giving up at least one day a week.

I am thinking of affiliation for educational purposes.. We can already send a patient to any hospital we want for service purposes.

Community Hospital Physician, Surgeon Post

We plan to reapply for a four year surgical residency. We need an affiliation in order to get interns and residents. The handwriting is on the wall.

Community Hospital Physician, Surgeon Post

One of the things I would very much like to see at our institution with regard to our problem of continuing as a teaching institution, I would really strongly like to see us become affiliated with a medical school. That would be a real asset. The advantages are tremendous and obvious. What we are really striving for is better care of our patients. I don't think there is any question that this can be done if we are a teaching institution. The individuals on our staff will have to give up some of their time. If they are unwilling to do so, they should not have the benefit of association with students or house staff. That divides the staff into teaching and non-teaching. We have this now in a way. Only members of the teaching staff have interns and residents. There is no doubt that this is an advantage. It makes it easier to have someone cover for me. It might even be 50:50 now. I don't know. I have never discussed the reluctance of the non-teaching staff with them. Maybe it's just a disinterest on

our leadership, we'll have to try to affiliate. We have the case material, the physical plant, and the nucleus of staff that would be willing to go to any extreme to continue the training programs.

Our department head is very, very anxious for affiliation because although he feels the present program is good, he perceives the trend away from the non-affiliated hospital. He has seen the young student turn us down because he is uncertain about how he will be able to continue his education in our hospital. Here it is a gamble for him but it is no gamble with an affiliated hospital where he knows he will be exposed to the rapidly changing knowledge and where he can stay up to date with greater facility.

The Exchange Program has crystalized the feelings of the staff. My discussions with the staff is that the men doing the teaching and who want to do the teaching want affiliation, very, very much. I think we feel our short comings and weaknesses and see the importance of continuing medical education. I am sure there are others who don't.

Community Hospital Physician, Surgeon Pre

In order to get interns, the hospital has to be affiliated. This is because of the trend towards specialization. The student feels he should do his internship where he thinks he has a good chance of getting a residency.

Footnote (1), to page 70

Community Hospital Physician, Surgeon Pre

It would help the community hospital to affiliate with a medical college. There has been a fair amount of discussion of this. I feel this is the answer to more interns and keepings standards of the hospital at a high level.

Community Hospital Physician, Obstetrician Pre

I want to learn this week what the differences would be with affiliation. I want to see how the coordinated program with a strong director and staff with the prime goal of teaching residents, interns, and students treat patients in comparison to the way we do.

The majority of medical school graduates go to affiliated hospitals or medical school hospitals. The medical school will have to help us if we continue with residency training programs and if we are to continue to enjoy the injection of new young physicians into our community. We'll have to help by having visiting professors come to us so we can keep our program up to date or we will have to make every effort to affiliate with a medical school. In exchange, we'll ask the medical school to show us where we are wrong, to come in and do it. We'll take your people as our chiefs and department heads. Our hospital is expanding and we have to accept the fact that in competing for interns, we will have to give up just enticing them. We will have to have a guaranteed program. If we can't do it ourselves with

Exchange Program was the expressed desire which emerged there with regard to their seeking an affiliation with a medical school. This interest in affiliation became obvious a short while after the beginning of the Exchange Program in the taped discussions which were conducted with the physicians participating in the Exchange Program. (1)

It may be noted that there is nothing obscure or subtle about the motivation for such affiliation. Although there is some mention of possible improved patient care, the major emphasis is clearly upon this as a means by which the hospital might be better able to guarantee a flow of house staff. The intensity of the desire for such affiliation on the part of some community hospital physicians was probably underestimated at the medical college. The hope of obtaining such affiliation was later recognized as adding significantly in negotiations with the community hospital about issues in continuing the Exchange Program.

In any event, it seemed a foregone conclusion that the community hospital would seek some sort of an affiliation with the medical school. It was not surprising, therefore, on March 24, 1968, less than two weeks after the last of the exchange visitors from the community hospital returned home, that the Medical Director/Director of Medical Education of the community hospital came to the Dean of the Medical College soliciting establishment of a formal affiliation between the two institutions. The request was for a "full affiliation" involving medical

students, house staff, and others. He himself stated that this request was a result of the Exchange Program although he indicated that interest in this sort of thing had also been generated as a result of a new awareness of what was going on in the rest of the medical world as a result of staff interest taken in the Coggeshall report and others. He said that the staff had set up a "goals committee" (Educational Planning Committee) which was concerned with "keeping ourselves sharp" and which had discussed multiple ideas but had delegated himself to bring up the matter of affiliation with the medical school, "but to make no commitments."

While it is clear that there are a number of motives involved in the desire for affiliation with the medical school on the part of the community hospital, whatever interpretation is taken, affiliation implies some evidence on the part of the physicians at the community hospital to give up some of their independence and educational isolation. No doubt the physicians at the community hospital had a variety of ideas about what an affiliation would entail for them. It would be expected that most of them expected some increase in the prestige of their hospital, some improvement in their hospital educational programs, increased numbers of house staff, and no doubt some relaxation of their own educational activities as these might be turned over to medical school physician educators. The desire for affiliation thus suggests not only maturation in terms of their giving up splendid isolation, but regression

in its expression of increased dependency needs. Given the circumstances of the request, it was obviously premature to negotiate any comprehensive affiliation with the community hospital. That institution would have to find its own educational strengths and the medical school could help it in this activity through the Exchange Program. Response to the request for affiliation therefore was non-committal except to offer Graduate Affiliation (Type "G") which only recognizes that programs at the community hospital are set up on a regular basis utilizing some of the medical school staff.

Affiliation may be a powerful device to extend medical education at all levels from the medical school to the community hospital. The danger of premature affiliation however is that it throws the responsibility for initiating programs of an educational nature onto the medical school and it does not necessarily involve extending the educational activities of the community hospital under its own initiative. This is inconsistent with the goal of the present Exchange Program which is not merely to have the medical school assume the responsibility for doing these things but to get the community hospital physicians to do as much of this as can be done. The goal of all continuing medical education programs is to increase the educational involvement and participation of practicing physicians appropriately and not to relieve them of their responsibilities. For this reason, it is important that the community hospital

Footnote (1), to page 73

Jefferson Medical Center Physician, Post

I feel they have as much brains there as we have. I'm as sure of this as when I went up. But many more of their people are overworked than ours. The salaried people here do not have the cares their people have who have to practice for a living. This allows us to spend more time in conferences and educational matters. They don't realize they have as much brains as we do. They have a feeling that there is a difference between town and gown and they feel they are not as inherently capable as we are to come up with answers. They feel we have some built in peculiar ability to handle these things. This is because they are so harassed by the workday problems that they don't have an opportunity to sit back and view the problems. I confessed my surprise to the people there and told them that we had no more answers than they have even though they look to us for them. This is a dialog situation and they have to talk to themselves just as we have to talk among ourselves and back and forth but they don't get the opportunity to do this. I told them they have to come up with their needs and tell us what they want from us. They have the erroneous idea that they have only to bring in full time heads of departments to solve their educational problems. I think we should involve all of the hospitals in the area.

should have a dialog with itself. It is less important for the community hospital to know what is "expected" of it in an educational affiliation than for it to develop its own ideas about what it has to offer. (1)

The desire for affiliation, therefore, represents a tangible and an important change in the community hospital's orientation with regard to the outside world. It does not necessarily reflect a profound change in terms of the communications activities at the community hospital. It suggests that there are now perceived to be things which need changing, but the prescription for change is based upon the symptoms and not upon the disease. The community hospital leaders, for example, have not perceived their own internal communications problems; they have not perceived the need for more extended two-way communication and dialog with themselves and with other members of the medical community.

There are judged, therefore, to be three general areas in which the Exchange Program had impact upon the communications activities at the community hospital: 1) As an institution, it was moved off "dead-center" and started to make or attempt to make some commitments outside its periphery and to organize itself somewhat better in terms of its educational program. 2) Contacts were made between the staffs of the two institutions independent of the official channels for communication.

Insofar as the official channels are noted to be present actual or potential obstacles to truly significant changes in the community hospital, this limited breakthrough is judged to be of some importance.

3) Individual physicians' communications activities were altered as they began thinking about some of their problems with new perspectives.

Some of the institutional changes may be recorded in the desire for affiliation with a medical school, in moving to require minimum attendance at weekly medical conferences by all physicians on the staff, by establishing a budget for educational programs, by seeking to appoint full time men to be chiefs of the major departments within the hospital, by delegating physicians to identify areas of performance deficit within the hospital which might be corrected through educational programs, by expressing the desire of the institution to continue the Exchange Program, by making changes in proposed renovation of facilities of the Department of Radiology (including the early resignation of the chief of that department), and by establishing the above mentioned Educational Planning Committee.

These institutional changes should not be exaggerated, especially in view of the fact that the Community Hospital is somewhat notorious for making elaborate paper plans which are not necessarily implemented. For example, the Medical Director/Director of Medical Education has expressed considerable ambivalence about enforcing the "50% rule". This rule, passed by the Executive Staff of the community hospital following the conclusion of the Exchange Program, requires all staff physicians at the hospital to attend fifty per cent of weekly medical staff meeting in order to keep their admitting privilege to the hospital.

The existence of the Educational Planning Committee did not guarantee that it would function or even that it would be concerned with all of the educational planning at the Community Hospital. In fact, its meetings have been sporadic and the Medical Director/Director of Medical Education has indicated that he has found no occasion for it to meet in the past seven months even though a counterpart committee set up at the medical college has held regular meetings. The committee had no clear specification of its authority or the range of activities it should consider. Subsequent events have revealed that few of the physicians on that committee had any idea at all about some of the major educational plans and activities which were actually being planned and developed at the community hospital for the house staff there. The emergence of a committee such as this however no doubt reflects the fact that something is happening at the Community Hospital, largely in response to the Exchange Program, and it seems most likely that the Medical Director/Director of Medical Education is already beginning to experience pressures for change which are new and perhaps threatening to him.

Ideally, pressure for change should come from the top. The function of leaders is to lead and to produce orderly change. Where pressure for change comes from below or outside there is likely to develop resistant at the top and an unstable situation is likely to emerge.

to this. I think this will be realized eventually. We are trying to change our constitution to make doctors attend weekly conferences to belong on the staff of the hospital. Or he should make him attend some conference somewhere, like Rotary. I think something like this will have to be done. It is expensive and it takes time to have our programs.

Community Hospital Physician, Surgeon Post

I attended the Journal Club. We don't have this in our surgery department. I think it is a good idea. It's good because it stimulates one to read the journals. If nobody will attend or discuss, there's no point in having it. I didn't get too much new information from either of the conferences I attended.

rare treat; it is a luxury that those interested in teaching should be interested in. Teachers need a better background of knowledge. The knowledge that is picked up is bound to be passed on.

Community Hospital Physician, Pediatrician Pre

We may get to the point where we need an in-patient director for pediatrics to stimulate ourselves to learn. As far as education is concerned, my needs are not met in the hospital.. I miss the academic atmosphere. It's a matter of improving our conferences.

Jefferson Medical Center Physician Post

A benefit of the Exchange Program is for community hospital physicians who concentrate a large amount of their time on office work and do not study enough. This offers some opportunity for "change". There is too little discussion and controversy, too little consideration of different approaches by the community hospital physicians. Visiting faculty bring in new ideas and controversy and the possibility of change.

Community Hospital Physician, Internist Post

I think we are wasting a lot of valuable talent to direct our teaching endeavors to the same small group all of the time. If so, something should be done to make it so that more physicians are exposed

Our staff in its weak areas can be reactivated and its interest rejuvenated by the enthusiasm of the right administrator. Many men become so busy and involved in their own practice but have come from very academic residencies, had in their former years as residents exhibited an interest in the academic, wrote papers and were very productive.

Community Hospital Physician, Obstetrician
Group Meeting

It would perhaps be better to spread it over more men in the department. Maybe some men should only go for three days. The exchange might then accommodate a special interest approach. It is an experience that everyone on the staff should have. The real meat of the visit was to get into a special interest field not available in the community hospital area, where the knowledge was not available and the sub-specialties are not available. I would like to spend five days in cyto-genetics and genetic counselling. I would like to be able to talk about this with the pediatrician so that we could better counsel parents. The entire staff needs an opportunity to evaluate themselves and the effect is limited until this is accomplished. All the people who are teaching interns and residents at least should be involved. The ob-gyn residents at Jefferson have asked to come and see the operating suite at the community hospital. This is not a mass education program; it is on a man to man basis and therefore a

had technicians and funds, it's not without the realm of possibility for busy individuals including clinicians to conduct research. This has opened my eyes because men in clinical practice may know of interesting projects that might be carried out and which might not be thought of in a teaching center. There might be an untapped reservoir. So many projects are far from the clinical field and seem to be repetitions of what has been done before.

We have such a good coronary care unit, we have all wondered about what kind of statistical and other data we might work up. We have an IBM system which most of us staff men have been uneducated on. But our medical records are skillfully arranged so that studies can be made. We do not have a biomedical statistician. I'm hoping that Jefferson faculty coming to the community hospital will help us find potential areas for clinical research.

Community Hospital Physician, Obstetrician Pre

I think the Exchange Program has had impact upon getting men back into the fold. I recall one conference I attended where the visiting physician brought the conference to life, stimulated a good bit of discussion from the floor, and the residents were busy taking notes. I learned by going to this conference. The injection of an enthusiastic man from another institution is very, very good.

Footnote (3), to page 76

Community Hospital Physician, Internist Pre

Most physicians today are practicing in their offices most of the time. We need to think of ways to increase their efficiency in their office. We need to allow for more time for the doctor-patient relation. The medical center can help the doctor both in and out of the hospital. Doctors should be offered the opportunity periodically to return to their medical school. I think most doctors nowadays are getting the idea that they need some time each year for a vacation and also for continuing medical education. Most have one organization that they are willing to devote some time to. Most doctors, if they thought there would be something enriching to the experience, would not hesitate at all to take part.

The man in the general practice can probably contribute a lot to medical educators just as medical educators can come to small areas. The artificial conflict of town and gown is something that is a very unfortunate thing. They must get together. Medicine must become more organized for better patient care. Some of us get the idea that the academic types don't like people, that they are shy and retiring and that they don't really practice medicine. There would be a better relationship all the way around with improved communication.

Community Hospital Physician, Internist Post

I got the impression here that if a person had a desire, and if you

Footnote (2), to page 76

Jefferson Medical Center Physician, Post

In making rounds, I found physicians asking questions about whether the consultants were right about something. They indicated this was something they had not done in the past. Some of the leaders attribute their present self-criticism to their contacts down here. At least this is what they say. I am inclined to believe them because no matter how the exchange is run, it still represents a loss of income to them and the mere fact that they make the sacrifice even though it is under some group pressure that they should participate, but they don't have to say subsequently how good it was. Now they are talking about the desirability of continuing it.

The impact of the program has been on a limited number of physicians. It is at the level of the current leadership or the next generation of leadership. The apparent successor to the present head of the department of medicine practices good medicine but he has not communicated adequately to others to this point. He is now talking about his interest in conducting teaching rounds. In this community hospital, when they have house staff they do not schedule rounds at any particular time but at the convenience of the attending physicians. When they do get there, many of them have the tendency to get this phase over as quickly as possible so they can attend to the other pressures of work. They certainly do have some teaching potential however.

Footnote (1), to page 76

Jefferson medical center Physician, Post

The medical director has been altered. He previously was a rock of Gibraltar in resisting change. Previously he was the only person I could talk to; I could not canvas the staff. This program has led to a lot of discussion with regard to their needs in education. They are now asking about where the hospital is going. They are not just talking about how many patients they have but about what they are going to do so many years hence and how they can plan to remain a quality hospital. How can we see that the staff in our hospital is a top flight staff? They have begun to compare medical practice there with medical practice in a medical school. Sometimes when they come here they find that the quality of care in their own institution is wanting. Previously up there, there would be no one to say that one was off base giving or treating a patient in a given way. As community hospitals go, this hospital is a good one but not nearly as good as it should be. It should be the real leader of other hospitals in its area but it is not.

This raises the question of whether it is desirable in the interests of institutional stability to continue an Exchange Program which is likely to stimulate a greater demand for change than the present organization of the community hospital in fact can handle.

With regard to the extra-mural communication stimulated by the Exchange Program independent of the official channels of communication, the following comments are appropriate from the Director of the Exchange Program who also participate in the program as an exchangee: (1)

Perhaps the most striking expression of change therefore must be reported on the individual level. As perceived by visiting academic physicians, this change has to do with changed expectations and perceptions of the community hospital physicians. (2)

Support for these outside impressions is obtained from the statements of the physicians themselves with regard to what they perceived to be necessary for change in their institutions in terms of communications activities. (3)

Community Hospital physicians visiting the medical center also were impressed by a number of moreorless technical features of the medical college communications activities. Not all of these could be directly transported to the community hospital. However, by being exposed to

Footnote (4), to page 77

Community Hospital Physician, General Practitioner Post

You can be rest assured that my partner will be on the telephone to-
night asking me what happened here this week.

Footnote (3), to page 77

Jefferson Medical Center Physician
Group Discussion

We have already gotten to the outside physicians. The vast majority of physicians when they have a problem send their patients to the hospital where a physician sees them there. The knowledge goes back.

Community Hospital Physician, Director of Medical Education
Group Discussion

The ripple effect has already happened in the short time that the program has been in effect. Dr. _____, for example, gave the staff some changed concepts in the care of individuals with kidney disease. The word went out as these physicians were called upon as consultants. Although they may have already been hearing this same thing, they heard it phrased in a different way. The hematologist was seen as a veritable dynamo. These are things that affected the patients in this hospital. These things have already had an effect upon the care of our patients today. (another doctor at this meeting also confirmed the presence of the ripple effect)

Footnote (2), to page 77

Community Hospital Physician, General Practitioner Pre

I am not aware of any other discussion of the problems of the general practitioners except for the one you and Dr. _____ had with them in January. This is due to their not wanting to face their problems. They came to that meeting on a basis of curiosity. There has been no further discussion as far as I am aware and so I don't know of any other result except for Dr. _____ and myself participating in this exchange.

of meningitis. I wondered what they could say about it but Dr. _____ talked about it from a different point of view and it was excellent. There is something but it takes some originality. They fill up the room. We never had nurses attend our conferences. The nursing students don't either. There is nothing more disconcerting than to have a conference with only three people sitting around. There is no reason why nursing students couldn't attend, but the conferences have to be improved. But it requires a certain kind of a person with a little originality. Some people are just born teachers. Some have to work hard at it.

Community Hospital Physician, Surgeon Post

Before I was engaged in this program, I did not know a single person at Jefferson, except by reputation.

Jefferson Medical Center Physician, Post

I think they would be interested in having a tumor conference such as we have here. The group attending conferences are hungry for this.

Community Hospital Physician, General Practitioner Post

I think the video tape idea is good. I would certainly be in favor of it. Even just a sound tape of your lectures would be good so you could sit and listen at your leisure. I think the audio digest tapes are excellent because they are so convenient.

I think the team approach was illustrated in the pediatrics conference. On one case they had a matter of ten different consultants.

Community Hospital Physician, Pediatrician Post

Here you can sit at the lunch table with five or six different doctors and discuss things. It doesn't happen at the community hospital because everyone has a different schedule. I said that this is wonderful what you can do to one of the staff physicians here. She said that when she was in private practice it was impossible. There is a difference because the demands that are made are so much different. That's why the atmosphere here is so different.

We don't have any opportunities to see movies relating to the general subject of pediatrics. But I just got a brochure listing free films. I was thinking about using them.

When you look and see who comes in to the pediatric conferences, you see nurses, medical students, and practitioners, but they come for a reason. The conferences are very good. Yesterday they had a case

and my own type of practice. We all have the same kinds of problems.

Community Hospital Physician, Physical Therapist Post

I've spent the week with the group in the Rehabilitation Center. Their clinical material is similar to what we have. We may have a little more in the way of trauma. The conferences start off with asking the nurses their observations of the patients which we are inclined to bring up last. I believe it gives a truer picture to have the nurses telling the physicians because they are in closer contact with the patients. Then men here find out right off if the patient is using the things the various therapists prescribe for them. Often you instruct people and they never carry through.

One of the things here is that they have a very good conference room in the rehabilitation unit. It is so good that it attracts the other specialists. Usually rehabilitation units are tucked away in the basement and out of sight, out of mind. This brings the physicians to the conference more and they think in terms of using it more.

I was particularly impressed with the way they were teaching medical students here. One student was assigned a case and he had worked with the speech therapist so that he did a good job of eliciting communication problems utilizing a one way mirror. He was guided to ask questions that would demonstrate the patient's problems without frustrating the patient. I noticed that the therapists all came very well prepared to the meetings.

Footnote (1), to page 77

Community Hospital Physician, Internist Post

I met a great many people in the coffee shop here and we discussed many things about teaching and medicine. You can't go through the hallway here without seeing a person whom you want to talk with regard to some problem.

We can learn mass means of education with the fewest number of faculty members. Yesterday I attended a cardiology conference and I was given a plug-in stethoscope phone which we plugged in and listen to as a team with a dozen others. We don't have something like this at the community hospital. This is nice to have.

I found a number of other good ways of teaching students in talking one night with a former class mate. We are starting to use the methods that are used here.

A professor of medicine in a medical school and a department chief in a community hospital have many common problems. We try to get the best people we can. He told me how to get the right man and how he could bring his own group with him. The internists agree that we need a young gastro-enterologist.

As a result of this experience I think I have more sympathy for the physician in the ivory tower. I think I understand the problems of the teacher in the medical school. It helps me to understand myself

a greater concentration of medical communication and by becoming aware of the difference from the communications patterns in the community hospital, some pressure for change may have been generated. (1)

Noting the isolation of the general practitioners from the communications activities of the hospital, it would seem unlikely that there would be very much effect upon them in terms of their interest in the program or other educational activities at the hospital. This seems confirmed by a comment from one of the two general practitioners who eventually did participate in the program. (2)

On the other hand, there was a suggestion from at least some of the participants in the Exchange Program that there had been some indirect effect of the program upon non-participants, what was called the "ripple effect." (3)

In general, however, insofar as the hospital really lacks an effective communication system for the dispersal of information to staff members (apart from memoranda mailed by the Medical Director/Director of Medical Education), information obtained as a result of the Exchange Program may be expected to have been circulated in the limited person-to-person contacts within the small groups previously identified. (4)

Communication is especially important in planning of activities and also of technological changes to be made. The communication between

Footnote (1), to page 78

Community Hospital Physician, Director of Medical Education

The visit of Dr. _____ was the finest shot in the arm any institution could have had. It started off sensationally. He was terrific. He talked to a lot of people. He scared the radiologists. He studied their plans for expansion and said they were good--for 1948. The hospital administrator did not like to be told this, but after a week he said that they were good--for 1938. Thereupon they threw out the whole plan. The head of the department has since announced his early retirement and this gets rid of a "millstone." He has sat upon the department and pulled it down. He has old equipment; he did not go along with the times. He was a "skeleton" in our closet.

the medical and the administrative units of the hospital seems to be limited to the medical director and the hospital administrator with a loose supervision of the board of governors. How this can have an impact upon the functioning of medical matters is well illustrated through the comments of the Medical Director/Director of Medical Education concerning the visit of the head of the department of radiology of the medical school to the community hospital. (1)

Prior to this visit, there had been no mention of any plans for expansion in this area nor of any problems with "millstones." Had there been a well integrated committee concerned with overall future planning for the hospital, it is quite likely that they could have solved their own problems quite easily. In most such situations, the problems are "known" by all who are concerned and interested but there is a lack of communication whereby individuals can feel comfortable in voicing their true feelings. The threat of reprisal in one form or another may be a strongly inhibiting factor. The visiting "expert" is under less threat of reprisal and he may even be expected to find defects which are obvious but ignored. The outside consultant may thus expediate changes for which there was already considerable latent interest.

It may be concluded therefore that the Exchange Program was not without effect in terms of inducing changes in the communications system at the community hospital. The significance of these changes, however,

should not be exaggerated in view of the nature of the resistance of the community hospital to change. Whether the changes which have occurred will be permanent is uncertain. There does now exist at the community hospital, however, a minority of physicians who are aware of their needs, who are ready to do something about them, who recognize one another, and who are young enough and energetic enough to provide educational leadership for the hospital in the future. In no small measure, they have been identified and supported in their objectives by the Exchange Program and it is no doubt to the medical college they will turn when there is the possibility for real implementation of an active educational program at the community hospital.

Library Attendance

One of the measures selected to evaluate possible effects of the exchange program upon communications activities at the community hospital was utilization of the hospital library. A gross observation was selected, that of a daily enumeration of physicians entering the library for any purpose whatsoever. The library is a pleasant, clean, and quiet room with some 5,000 bound volumes and 120 journals regularly received. The determination of library utilization selected by the medical director of the hospital was limited at the outset of the program to a self-reporting in a book placed on a table at the doorway leading into the library.

Cursory examination of the names recorded in this book revealed that self-reporting started off very well but with the passage of time, physician resistance increased to writing their names each day they entered the library and some began to refuse to do so even when prompted by the hospital librarian. This, of course, would suggest quite erroneously that the effects of the exchange program had been negative so far as utilization of the library was concerned. Consequently, when it became clear that this system of measurement was grossly inadequate, a new technique was introduced whereby the librarian herself was now encharged with unobtrusively recording the names of physicians entering the library on a daily basis.

Because the librarian was much more methodical and reliable in recording than was the previous system, her tabulations do not show the fluctuations characteristic of the first period, but the variation in quality of recording from the first half to the second half of the program compromises the possibility of making comparisons between library utilization during the periods. There does now exist, however, baseline information obtained through a reasonably reliable source which does give information about utilization of the library during that portion of the day the librarian is present. However, because the library is open all of the time and because the librarian is present only from 8 AM until noon, there is also some question about how far one may go in interpreting these observations. The results nevertheless are worth reporting because they are consistent with what would be expected and because it is probable that there is a good correlation between attendance at the library during the morning and during the rest of the day. Insofar as most physicians, if they come to the hospital at all, are likely to do so during the morning when they make rounds and attend meetings, this measure has some merits. It would seem quite unlikely that a large number of physicians would attend the library with any great frequency during evening hours without the librarian ever being aware of this. It is known, however, that the library is used some times during hours when the librarian is not there because books are left on reading tables which are not there when she leaves at noon time.

working, therefore, with the limited information available, some observations of considerable interest may be made. By far the largest number of visits to the hospital library are made by the house staff and figures relating to them were therefore omitted from overall averages to be presented later. Perhaps they do so because they have nothing else to do; perhaps there are no other equivalent medical libraries available to them as there may be to the rest of the medical staff; perhaps their need for basic information is greater; perhaps their responsibility for preparation of case conference material obliges them to visit the library more. In any event, one member of the house staff was observed to enter the library up to 75 times during the entire year of observation. In fact, by looking at the figures relating to the attendance of physicians at the library, it was possible to recognize house staff simply on the basis of the frequency with which they went to the library. One member of the attending staff was observed to enter the library some 155 times during this same period but he was the head of the library committee and he was therefore also omitted in the computation of group averages insofar as he was so atypical of the rest of the group. Otherwise, only three attending physicians were observed to enter the library more than 20 times during the year, 25 being the greatest observed frequency for anyone in this group. In general, therefore, visitation to the library was an exceptional and not a routine activity for the physicians at the hospital whether

they were reporting their own attendance or being observed by someone else.

It may be further noted that a total of only 80 members of the attending staff at the hospital were observed to make any personal use whatsoever of the library. Although it is possible that some may have made indirect use by borrowing books loaned to their colleagues or by coming only during hours when the librarian was not present, given a total physician population of 145, only 55% of the total group are thus represented at all. It seems quite unlikely that the other 45% would have made any extensive, unobserved use of the library.

Of even greater interest is identification of those individuals who did make use of the library, at least under the conditions of observation noted above. The medical director of the hospital listed ten physicians at the conclusion of the exchange whose medical performance he estimated to be superior but who had not participated in the exchange and he also identified eleven physicians whose medical performance he estimated to be below average and who also had not participated in the exchange. In addition, there were the 18 physicians who did participate in the exchange as discussed elsewhere. A fuller comparison of these groups is also offered elsewhere, but it may be noted here that the better physicians with only one exception were all observed

to make some use of the library during the year of observation. On the other hand, only three of the below average group were observed to make any use of the library at all. One could discriminate between the two groups with very little error, therefore, simply on the basis of whether or not use had been made of the library during the period of observation. With regard to the experimental or exchange group, the matter was somewhat more complex. Here it was found that five of the 18 physicians were not observed to make any use of the hospital library during the year. Of these five, four were noted to be surgeons of one sort or another. Insofar as the surgical department is generally considered to be the most loosely organized department, this finding is by no means surprising. By contrast, only two members of the department of medicine in either the better group of physicians who did not participate in the exchange or in the experimental or exchange group were not observed to make use of the library even though there were many more members of the department of medicine at the hospital than there were members of the department of surgery. This is consistent also with the greater conference activity in the department of medicine than in the department of surgery. It is also consistent with the reported observation that surgeons tend to be more action oriented whereas internists tend to be more introspective and reflective.

The total utilization of the hospital library by other than house staff and the chief of the library committee as noted above was limited to some 80 physicians. Under the self reporting system of observation in use the first six months of the study, the mean utilizations per physician making any use of the library during that period was 2.89. This means that the average physician who used the library at all during the period did so somewhat less than once every two months. During the second period when the librarian made the observations, the utilization rate for those making any use of the library during the period was 4.32. This rate increase appears to be more a function of improved observational techniques than of any real change in library utilization. With this data now available, however, continued observation may demonstrate whether the ultimate effects of the program can be measured in this dimension.

Attendance at Hospital Medical Staff Conferences

An important index of the educational activity at the community hospital is the attendance at the hospital's medical staff conferences. These are generally organized by department. Most departments meet weekly but the medical department meets daily. Reports from both the community hospital physicians and the visiting academic physicians indicated that attendance in general at these conferences was low. Moreover, community hospital physicians stated that in their opinion the physicians who "needed" to attend were unlikely to do so. Data was collected on conference attendance for those conferences at which Jefferson Medical College faculty were present. All physicians on the staff were advised by the Medical Director of impending visits and one would expect greater interest to be exhibited in these conferences than in ordinary conferences. Not all of the supporting data has as yet been transmitted from the community hospital but from what is available, support can be given to the reports about physician attendance mentioned above.

For convenience, the present data has been divided into two periods, one from March 1967 to June 1967 and the other from September 1967 to December 1967. The period between January 1967 and March 1968 will be reported later.

during the first period there were 29 recorded medical department meetings. Members of the department of medicine account for 83% of the attendance. In addition there were occasional pathologists, radiologists, and others. The mean attendance for all individuals who attended any meetings was 11.08. The great variation in attendance however is indicated by a standard deviation of 8.10. If only members of the department are considered, whether or not they attended any meetings, the mean drops to 10.0 and the standard deviation increases to 9.22.

During the second period there were 13 recorded conferences. Mean attendance here for all individuals who attended any conferences during this period was 5.77. Attending 5.77 conferences out of 13 is somewhat better than attending 11.08 out of 29 conferences (38.2% v. 44.4%). However, as would be expected with a smaller number of conferences, the total number of physicians attending the 13 conferences was smaller than those who attended the 29 conferences (18 in contrast to 25).

What is striking in the data available is not only that relatively few physicians account for most conference attendance, but that these individuals are the same for both periods and they are generally classified as better physicians by the medical director.

If, for example, one takes the eleven physicians whose attendance at medical conferences during the first period was above the mean of those who attended any of these conferences at all, the following observations may be made:

1. All but one of these physicians either participated in the exchange or was designated as a better physician by the medical director.
2. Only three general practitioners participated in these conferences; These included the two who later participated in the exchange and one who is classified by the medical director as a better physician.
3. All four of the pathologists attended some meetings, the most frequent attendance coming from the one pathologist who participated in the exchange.
4. None of the general practitioners and none of the pathologists attended as frequently as did the average member of the department of medicine who did attend.
5. Apart from the general practitioners and the pathologists, all individuals who participated in the exchange attended meetings well above average.

During the second period it was noted that every one of the physicians who attended the medical conferences above the mean of those who attended any of the conferences in this period was listed in the first list. None of those individuals who participated in the exchange failed to attend meetings. The same three general practitioners were observed to continue their participation in the conferences and three of the four pathologists also did so. No additional general practitioners were observed to attend any of the conferences. It is also noted again that none of the physicians designated as less up to date by the medical

director participated in any of the medical conferences during this period.

One can fairly easily predict attendance at medical staff meetings from one period of time to another. There is also likely to be a strong correlation between the impression of medical competence of a physician by the medical director and the physician's attendance at medical conferences in the hospital. Other correlations will be explored.

Changes in Medical Practices on the Part of Program Participants

It was not expected that following the course of only one year of operation that the Exchange Program at the community hospital would produce any significant major change in the quality of medical practice either on the part of the participants or the rest of the physicians in the hospital. In large measure the program was not structured to produce such change, at least as an immediate effect. Moreover, it would be difficult to attribute general changes to the effects of the program insofar as there is a slow pattern of change in medical practice which is believed to be rather universal occurring with most physicians in most hospitals. The Jefferson Medical College faculty are in possession of relatively few unique bits of information, apart from their research work, which might not arrive at the community hospital through other avenues. The "ripple effect" proclaimed by some of the community hospital physicians is, to the extent that it does occur, not a function of the Exchange Program but of their ordinary system of communication and describes the fact that there are a leading group of physicians who are more likely to introduce new ideas to the rest.

Nevertheless, an attempt is being made to make a formal evaluation on a very limited basis. The results of this evaluation are not presently available and are not expected to be available until at least April 1969. The evaluation is based upon comparative measurements made on physician performance in handling moribund patients in the period im-

mediately preceding the Exchange Program and in the period immediately following it. The comparison also includes in addition to patients whose physicians participated in the exchange, physicians who are known to be active in the educational program of the community hospital and physicians who are known not to be active in that program. Presumably such a study could reveal differences in the handling of moribund patients, at least, between the different groups and as a function of the passage of time. In order to meet minimal statistical requirements, 64 records have been determined to be necessary but as of November, 1968, the community hospital has been able to produce only 62 meeting all criteria. While the samples of moribund patients may not be typical of patient care in general in the hospital, if physician inadequacy is responsible for patient mortality, this may be determined. It should be recognized however that some 20,000 patients are treated annually at the community hospital and without a rather large sample of this number, many questions about physician care of patients must be unanswered. Nevertheless, it is felt that there is no alternative to this kind of chart review if one wishes to evaluate the quality of medical care in the community hospital and that the best available "common denominator" on which to compare physicians with diverse interests was that of the moribund patient. Chart review, to be done properly, is a laborious process requiring extended physician attention. Some physicians state that they will not give over three minutes to a chart

review because they find it to be boring. Other physicians recognize that an hour may be required. This will help to account for tardiness in reporting this information.

Even at this time, it is possible to report that there are no apparent major differences observed across any of the categories under evaluation on the basis of a 12% sample of the 64 records (i.e., 8 records reviewed by two physicians each): Moreover, it is noted that while the reliability of the two physicians' evaluations is positive, the correlation between their evaluations is of a very low order. Continued exposure to this kind of activity and increased communication among chart evaluators appears to be necessary for this type of activity to be fruitful. Without it, however, quality control in medical practice can have only a very limited meaning and application. Rigorous continuing medical education calls, therefore, for a specially trained physician educator, one familiar not only with under-graduate and graduate teaching, but who is familiar with physician needs in practice. Some specialization is called for in continuing medical education and this at a time when only cursory attention is given to the pedagogical role physician-educators of undergraduate medical students. However, because the demands of continuing medical education upon the physician-educator may be greater due to its voluntary status of the physicians who are being trained, it is possible that expertise in a formal sense may emerge here more quickly than at the under-graduate level in many

Footnote (2), to page 93

Community Hospital Physician, Surgeon Pre

The function of the medical audit is not so much fact finding but to check on the quality of care in the hospital: Did the patient receive the kind of care he should have for his condition? Was the treatment the correct type? It is a good committee. There wouldn't be too much change though if we didn't have the medical audit in the whole activity of the professional staff. We have a high percentage of specialists in relation to general practitioners and almost all the specialists try to do what they think is the correct way of managing the patient and a good proportion of the general practitioners do this so there are not many irregularities. It's like a policeman in a well regulated community.

Footnote (1), to page 93

Jefferson Medical Center Physician, Post

In looking at the charts of patients which were audited by physicians themselves I found that some of the notes were very vicious and the physicians were heavily criticized. This is a new thing. The angriest notes were written by the medical director. He said he had just started doing this recently, in the last year. He is now down to the stage where he is rejecting charts because of inadequate history. He is setting very rigid criteria. The medical records librarian was not informed what the audit system was. I also found that they are getting no information at all out of the PAS.

cases. It is possible that training programs and workshops for the faculty of continuing medical education programs may greatly speed this process. In some cases, however, it may become important to find and develop ways in which to motivate the interest of the physicians-educators so that they will be willing to undertake these less exciting, but no less important parts of the teaching assignment.

The mere effort to make the evaluation described above may have some impact upon the ultimate quality of medical care given at the community hospital. It is virtually unique for a hospital to release complete copies of its records to another institution for critical purposes. Eventually the results of this inquiry will be reported not only to the Public Health Service, but to the medical staff of the hospital. Insofar as many of the criticisms are negative, but not "destructive", controversy may be expected. In the meanwhile, the hospital will have been subjected to more intensive examinations of medical charts in selected areas both by its own staff and by the medical college faculty. (1) Those physicians from the community hospital who are familiar with its medical audit activities generally concur in their belief that the quality of medical practice is kept high in part, at least, in the community hospital by the mere presence of a medical audit committee. (2) Extending the activity of this committee as indicated, if one may accept this reasoning and build upon it, it may be expected

Footnote (1), to page 94

Jefferson Medical Center Physician, Post
(Quoting the community hospital Record Librarian)

The PAS/MAP has simplified hospital record keeping but it is not used by physicians at all.

Community Hospital Physician, Post

I find the PAS material is frequently in error, perhaps because of the quality of the training of the people in the hospital who do the encoding. I could not find out easily how many gall bladder patients died. I also could not identify wound infections. It is a lot of extra work to go back to the original chart although this could be done.

that there will be some impact upon the quality of medical care given in the hospital, at least as reflected in medical charts, by insuring that the quality of medical audit itself is high by auditing the audit.

It may be noted in passing that largely in anticipation of the Exchange Program, the community hospital became a subscriber to the PAS/MAP service. One may wonder what impact upon the quality of patient care this may have had. There is no doubt that the information received from this service had value to the hospital administrator informing him about utilization rates on a comparative basis. However, the main purpose in joining PAS/MAP was to provide data for the evaluation of the quality of medical care given at the hospital. The PAS/MAP was to provide data for the evaluation of the quality of medical care given at the hospital. The PAS/MAP program was started at the community hospital in early 1966, about one year prior to the commencement of the operational phase of the project, but, six months after discussions were started between the community hospital and the medical college. It was found that the first six months' data, however, were highly unreliable and that the medical librarians needed extended time in order to learn how to abstract medical records accurately.

Discussion with community hospital physicians revealed that virtually none of them made any use of the data they received from the PAS/MAP on an individual basis. They stated that they found it to be confusing and time consuming to study these reports. Most of them relegated this material to the waste basket. (1) This probably reflected the attitude

Footnote (2), to page 95

Community Hospital Physician, Pediatrician Post

How can the PAS material be useful? (asked with doubt) I do this more or less on my own. At the end of each month, I list all my patients admitted to the hospital with diagnoses.

Footnote (1), to page 95

Community Hospital Physician, Medical Director of Education Pre

I explained the PAS material to the staff when we sent them their six month follow up on their patients. I would estimate that maybe three percent understood it and turned the sheet over to see what all these characters stood for. I certainly wouldn't have been included in that three percent the first time I heard it. This is only a gross way of auditing. The diabetics without blood sugars, the coronaries with EKG's. We've been going after single unit blood transfusions long before this came along. I thought there was one specialty surgeon who did this a lot but somebody has gotten to him somewhere because he has cut way down on it. We're not that far out; we have a hard time using it as an audit. There are not too many gross things you can look at. Universally the coronaries without EKG's had died as soon as they got to the hospital. Some are medical record librarian errors.

of the Medical Director/Director of Medical Education who could not see any immediate value to the data supplied by this service apart from administrative purposes. (1) He felt that insofar as there were relatively few gross deficiencies at his hospital, the data offered in the PAS/MAP print-out was too superficial to reveal any significant problems in the medical service offered in his hospital.

At no time was the PAS/MAP material the subject of any educational sessions held at the hospital. (2) The medical audit committee did not make use of it at all and its members were hardly aware of its existence except when it was pointed out to them. They preferred to work directly with the actual medical records on an individual case by case basis rather than on the abstracted data in number form obtained from the PAS/MAP computers. Although it is conceivable that a community hospital could profit from careful attention being given to this data, the physicians would no doubt need special instructions and guidance in understanding how to interpret it and use it educationally. It is debatable whether the extra effort involved in this would produce benefits over the usual medical audit system done well and in which all physicians participate in terms of improving the quality of medical service in the community hospital.

Because doctors prefer to work on individual case material, because

of this. I think there might be a few changes in this place. We may take Dr. ____ suggestion for better investigative work for the few endocrinological patients we have. Dr. ____ was interested in some physical changes in the operating room. I don't know if we will take Dr. ____ suggestion for the radiologists to do their GI series by motion picture. Actually nobody came back saying we are doing this wrong and it should be done that way. The exposure is short and it takes time to disseminate information around.

of even the smaller physical findings on their patients. It points out a very high quality of coverage. The evening rounds permits them to interpret the patient's progress better to the patient's family and to plan much better. I am going to try to implement this and follow this with my associates in the community hospital. The patients are always busy here but I find that they follow their patients here right into the dining room. I see it works ok and I'm going to do it.

One of the things I was especially happy about was the opportunity to observe a number of electro-myographic studies. I picked up improvement from a technical standpoint and also from an interpretative standpoint. They are able to get many more positive results as a result of their techniques here than I have been giving. I have been ignoring them. I have confined myself to things that are proof positive whereas here there is a tendency to carefully ascribe significance to other things. It makes the tests more useful. They also sharpened up my technique on nerve conduction velocity studies. I also had an opportunity to observe a special test for myasthenia gravis. It is something I can easily use. I knew about it before but just in passing. I don't think it is very new but I have not had the equipment for more than a year.

Community Hospital Physician, Director of Medical Education Post

I don't think there will be many changes in your place as a result

demonstrate good rotation in the shoulder. So I'll be using that a little more.

I notice that they are very good at letting patients do their own insulin administration. Patients are responsible to a maximal degree.

We use our flotation bed at the community hospital more therapeutically after a patient has bedsores. Here they use it if there is any serious danger that a patient will get bedsores. It's pushing me in the direction of making more use of this tool. I'll use it more.

Another thing they are using here that I never heard of before is a convenient urinal, a baby bottle in some cases. They push fluid intake here much more than I have. They talk about urine outputs of eight to ten liters a day. This washes out the infection and prevents stone formation. They are going farther on something that I already knew was important. I'll now push a lot harder than I ever did before.

Here they make the patient assume greater responsibility in finding a job. We tend to spoon-feed our patients more. It may be easier in a small community. I can think of cases where our system probably made the difference but this is going to make me think more. I don't know if it will change me. Neither of us have statistics, but it is something that is quite desirable.

The physicians on the rehabilitation unit here make rounds twice a day. They are very well acquainted with almost the momentary progress

it here too. I also learned about homonal disgenesis. I'm thinking more about goiter than before and I intend to do more reading on this.

Community Hospital Physician, General Practitioner Post

I was quite impressed with the Cardeza foundation and with pediatrics.

I can say that I was instructed in everything I attended this week.

I enjoyed pediatrics most because it was on my practicing level. They

didn't go into minutia. They discussed pertinent things I could use.

They were talking about treating mental ulcers in children and one

little point that I had never thought of was applying an antibiotic

ointment. They suggested using an ophthalmic tube rather than the

finger whereby this can be done more effectively.

Community Hospital Physician, Physical Therapist Post

I was interested in getting notes on their impressions on using anti-

depressants on rehabilitation patients. They are more enthusiastic

than I am. I will take another unprejudiced look at this. They use

anabolic hormones in connection with the anti-depressants which I had

not done. I think I can also improve the way I have been handling

patients with unstable knee problems from what I saw here. The men

here also use isometric exercises rather than the ordinary progressive

resistance exercises and this may be aggravating for some arthritic

patients. I can see some places for this. They are also more strict

than I have been on shoulder slings. They use it here until they

Footnote (1), to page 96

Community Hospital Physician, Internist Post

I have acquired a sort of panoramic view of what is going on here, which areas of clinical activity are most active, where Jefferson is able to contribute something to care of my patients at the community hospital. This includes several areas:

1. I was very impressed with the kidney section here.
2. I feel I have learned about the current indications for dialysis, the waiting list, the way to direct patients here, I feel I could pick up my telephone and get immediate response; I knew about this before but I didn't know how they would respond to referring doctors.
3. There is a cardiac surgeon I can refer my patients to, I changed my mind.
4. For metabolic problems I would feel comfortable in sending them here.
5. If I had an unusual case where there were complications or lack of diagnosis, and I would feel comfortable in referring such patients for consultation. I know which patients I might send here that would get treatment over and above what he would get at the community hospital.

I'm glad to say that I don't have to learn medicine all over again even though it changes pretty rapidly, thanks to the post graduate courses. I learned more about a special condition and I spent a full day on it working with Dr. _____ here. It pointed out an area in endocrinology that I really wasn't up on. I think it will be very practical in the community hospital and I want to talk with the neurosurgeons about it. I'm sure I'm missing another disease, hypoparathyroidism even though I'm looking for it, but Dr. _____ says they miss

the PAS/MAP data fails to provide statistical normative information, because it relates only to patients discharged up to six months earlier, and because of its bulk, the PAS/MAP information service has not been used in the hospital's educational program. Moreover, examination of the PAS/MAP print-out on a cursory basis suggested that the probable net result of extended analysis would be trivial in relation to the time, money, and effort involved and this measure was dropped as a means of measuring the impact of this program upon the quality of medical service in the community hospital.

In addition to this formal evaluation of medical records at the community hospital, nearly every physician found specific items of interest to him in the exchange which may be presumed to bear upon his mode of caring for his patients. This tended to vary with the physician, however, and to some extent with his specialty. The orthopedic surgeon, for example, was said to be disappointed with the Exchange Program; he was reported by the medical director to have said that he had a good time on his visit but that he learned nothing. By contrast, others had very instructive periods both at the community hospital and at the medical college. (1)

It will be noted that the kind of thing that the visitors learned tended to be non-dramatic and technical in nature. New conceptual material was not reported. One would not expect a physician in the course of a week to learn renal dialysis and to be able to transport the technique

excellent and really very good. Of the other five, three seemed that the diagnosis was not confirmed at all. They did get them out of the care unit but there was a lag time. If the patient is not moved in 24 hours, the suggestion is that he is not being observed closely. It is poor medicine to impose the extra financial burden on the patient. I also saw two patients in the care unit who were not being adequately treated. One died and the other was not being treated for the correct thing. Although they have eight beds in this unit, there were never over two people who needed this and sometimes there were patients there who didn't need to be there at all. The resident was caring for the patients who were being improperly treated. One was being treated for a cardiac arrhythmia that he did not have. The resident misread but not for the correct diagnosis. A fourth year medical student could have made the diagnostic differentiation. They may need an educational program on a basic level. They need some mechanism for spotting deficiencies. They also exist here.

Community Hospital Physician, Internist Pre

We hope there will be criticisms because our hospital is noted for making changes when there are good criticisms. Dr. ____ made no negative criticisms but he made favorable ones about our coronary care unit and other things. He probably will make some. He reviewed some of our charts and said our department should be commended.

Footnote (1), to page 97

Jefferson Medical Center Physician, Post

I don't find any great lag in their hospital. They are not back in 1940. They keep up by picking up the "spill over." There is a time lag but it is not across the board. Two or three years does not make a huge difference. They feel they benefit greatly by this exchange.

Jefferson Medical Center Physician, Post

In radiology, the men are definitely up to date for a community hospital, but they have problems in trying to influence people in other departments, who have rigid views.. The demands and requirements of the community hospital are not nearly what they ought to be. Special studies are increasing all the time. They do not realize the demands that will be made and they are not planning adequately in this regard. Initiative is lost to other departments because they didn't perceive there would be enough demand. Some people will not send things to the head of the department because they question the quality of his work. Even in the medical school in some areas we do not do as good work as people in their private offices. This is because of the pressures we work under.

Jefferson Medical Center Physician, Post

I audited ten charts from the coronary care unit. Of these, five were

to the community hospital. Such dramatic things as might be available at the medical school that the community hospital physician was not familiar with might not be appropriate for him even to become concerned with in any detail in such a short period of time. Also, many of the community hospital physicians are not without their own sophistication which they get from their reading, their attendance at national meetings, and through other usual communication means. The hospital is not antiquated in its facilities or in its concepts, at least if one looks at the better men there and these were likely to be the individuals with whom the medical faculty visitors came in contact. The medical faculty visitors rarely identified serious performance gaps in what they saw at the community hospital and many were quick to praise much of what they saw. (1)

The good marks the hospital received, however, should not be construed to make it appear that it had no defects and that improvement was not and is not possible. What is meant is that the defects were not grossly obvious. The general level of physician practice, at least as observed by most of the academic-physician-visitors was judged to have been good. However, with few exceptions, each observer did find areas where the hospital had defects both in terms of educational program and the quality of medical care given. Moreover, it was strongly suggested that it would be possible to have meaningful remedial programs in selected areas, either run by the medical school staff or jointly with the hos-

as the older preparation. Not knowing the basic similarity in mechanism of action, they are inclined to say that the new drug is best when in fact the absence of reported side effects is due to less experience with it.

of responsibility about where the place ought to be going. The department was willing to give up prerogatives about special studies, rather than lead in this. The others come in and impose it upon them. The men there don't have the responsibility for running the department they ought to have. They are doing a good job in terms of their patient care but they ought to share more in the general administrative attitude. They ought to have more say about what they are doing and where they are going. Superficial treatment is given to the advanced concepts. This would be noted in the care of patients with advanced cancer. The potentially curable cancer ought to be in the hands of somebody who is an expert in cancer and cancer therapy. Many of the patients are therefore not getting the kind of care they ought to be getting. The application of proven advanced techniques at a sophisticated level where they ought to be used is lacking.

Jefferson Medical Center Physician, Post

In a discussion at the medical conference of the side effects of two Beta-adrenergic blockers, they talked about the side effects of the older preparation (propanalol) and the absence (or few) of side effects of a newer preparation (satalol). In open discussion with them, I found that they did not understand the mechanism of known side effects of the older preparation. Since the mechanism of action of the newer drug is apparently the same, it is likely to have similar side effects

Footnote (1), to page 98

Jefferson Medical Center Physician, Post

They have a significant number of patients with pulmonary problems who could be ventilated. They have facilities for this but there are many more indications for this. They are not particularly oriented this way. They are probably not aware of this. An educational program might fulfill a function in this area.

There are some individuals in surgery who have seen a ventilator but have no idea about how to use it. Here, most individuals are familiar with it. This does seem to represent a time lag.

I saw a patient there and I suggested that if the patient were here, an arteriogram would be run. Only one or two of their surgeons do this. They are not as adept at this as is our radiology department. In this particular case the diagnosis was obscure and the people there were relying on clinical impression, when it would have been very easy to resolve the problem.

I was asked my advice on several cases. They didn't buy it on several cases, but it turned out that I was correct and I had a pretty good batting average.

Jefferson Medical Center Physician, Post

I was disappointed in the department of radiology. A more forward looking attitude might have been expected. There should be more feeling

pital's own attending staff. There was observed to be sufficient variation in the quality of performance observed in the hospital for one group of physicians to instruct other groups of physicians on selected topics. However, it should be emphasized that the purpose of the academic visitation during the initial phases was not to find fault but to make contact and to stimulate thought about educational needs through positive and not through negative suggestions.

Several of the medical school faculty also pointed to specific areas in which they perceived the community hospital to be weak and to need improvement which could be achieved through educational programs and some technological sophistication. (1)

A frequently heard impression was that whereas the specialists were up-to-date and active in the hospital's educational program, the generalists were neither up-to-date (with exceptions) nor active in the hospital's educational program (with exceptions). No documentation was available to support these charges but generalists and specialists are being compared in the analysis of the sixty-four deaths mentioned above.

It may be expected that specific needs at different community hospitals will be very different. Each hospital is likely to have specific

cases. Routine knee problems from an orthopedist will come down and get good treatment but unless there is a problem, I'll never see him. It's a matter of time. We don't have the ancillary personnel they have here. I am working with aides who do not have the training to use the judgement I would like. It makes the chief therapist nervous a lot of times. He's a little insecure because of this.

Footnote (2), to page 99

Community Hospital Physician, Physical Therapist Pre

There are a great number of cases that are simply not recognized as treatable. There is a need for physicians to recognize that the need is greater than they think it is. But over the past few years, physicians have been reaching out for help. There is not so much solo idea now in the past six or seven years. At our hospital, the cases are well diagnosed and they are asking quite early. The head of orthopedics before I went there insisted that the patients' charts go to therapy. In some places, this is never done. Everything I could want was already set up when I went there. We just have physical therapy at the hospital, not occupational therapy. I bring one in occasionally. The speech therapist also comes to the community hospital. The services of a psychologist have been available only on a consultant basis, not as much as you would like to see for day by day intercommunication with the staff to edify us. They only answer specific questions as trouble shooters. It would be better to confer casually.

In our rehabilitation conferences where we waste time is where there are psychological problems and we don't understand them. A real good psychologist would discern the underlying problems.

Community Hospital Physician, Physical Therapist Post

One problem I will have in applying what I see here is that here they see all the patients in the hospital. I see only the more difficult

larger medical centers because of the prohibitive expense that is involved. We are increasing the number of things we are prepared to do, such as cardiac catheterization. We have learned from men coming to the medical centers and taking knowledge back to the community hospital. In heart disease, stroke, and cancer, as well as all types of disease, we can carry this knowledge back home and put it to use. I don't know if it is better to have a person come to us or have some of our people come to the medical center.

Community Hospital Physician, General Practitioner Post

I think you could take almost anything and set up a worthwhile program at the community hospital. A program on chemotherapy or antibiotics-something you are using every day. It would be nice to keep abreast of the recent developments. I would not be much different from the university setting in my use of drugs but I would be from some of my co-practitioners, because of my more recent training. But I don't think a program of any sort should be delegated to just general practitioners, or whatever, except on the basis of interest.

Community Hospital Physicians
General Practitioners Speaking in Group Discussion

Dr. _____ feels that a major problem with most family doctors is in handling the minor psychiatric disorders. Dr. _____ mentioned that he did not recognize the various syndromes such as the "tired housewife syndrome." "I was missing these patients; I just wasn't seeing them. I had to learn these things on my own."

Footnote (1), to page 99

Community Hospital Physician, General Practitioner Pre

One of the biggest problems in starting practice was in handling private patients. We had no training whatsoever in medical school for this. I learned more about handling people in the service than anywhere.

Community Hospital Physician, Pediatrician Pre

I think our pediatrics clinics could be entirely revamped. It's the same as what was used in the 19th century. For a mother who has any sort of management problem--you can't even begin to find out the problems. You can't sit down to get to the basic problems. This is different in our office practice where we have private rooms. Each month we take turns at the clinic, but sometimes people (physicians) don't come. We've been static about this whole thing. Only three of the five pediatricians attend the clinic. We've talked about it for a long time, that it ought to be changed but we never really do anything about it. I can see no other way but to get a complete new physical set up. I imagine people have complained about this in the past but there are so many complaints in the hospital. I think Dr. ____ may be aware of this, but it's up to us.

Community Hospital Physician, Internist Pre

There are certain matters which will always be better handled at the

areas in which it is particularly strong and other areas in which it is relatively weak. Only through individualized study could the weaknesses and strengths be definitely identified. This, of course, underscores the weakness in many educational programs which rely upon more-or-less rigid and fixed "formulas", as if the needs were nonolithic and invariant from one place or person to another.

An important effect of the Exchange Program has therefore to get the physicians at the community hospital to become interested not only in their continuing medical education but in defining the areas in which continuing medical education may be of greatest help to themselves. Although the medical college faculty can assist in this, it is most valuable when the initiative for this comes from the community hospital physicians themselves. There is a danger, however, in the fact that the community hospital may be too close to the situation to have sufficient perspective to identify his most important educational needs and those of his peers. He may not know what he does not know and he may have no convenient way of finding out. On the other hand, many of the needs perceived by physicians may have "political" implications within the hospital or may require large expenditures of money for which there are priorities. (1)

Lack of personnel was frequently cited as the reason for failing to provide care and coverage of the scope seen at the medical school. (2)

Footnote (2), to page 100

Community Hospital Physician, Surgeon Pre

The main reason I am coming down here is that I am interested in learning some of the newer procedures in urology because we have certainly need for some of these. In our general type of work, I think you get a little stagnated by what's going on new.

Community Hospital Physician, Director of Medical Education Post

I couldn't have asked for any nicer treatment than what I got from the people I saw at Jefferson. I learned a lot. I learned most from talking to members of the house staff and the medical students, but this is what I wanted to do. I probably went with preconceived ideas and had them confirmed. I expected the standards of care were going to be excellent, the investigation was going to be excellent, and these things were confirmed. I saw only the patients of the top ranking people. I didn't learn anything specifically that we are doing wrong. I didn't learn any breakthroughs in medicine that I didn't know before. I made resident's rounds and professor's rounds -- as far as the practice of medicine goes, I didn't learn anything spectacular or that was brand new.

Those people who go to study a specific entity can't help but pick up knowledge. The people who went will get this, but the period of exposure is too short.

Footnote (1), to page 100

Jefferson Medical Center Physician, Pre

I am a firm believer in satellite hospitals. They can do almost anything in a satellite hospital once the answer has been given in the medical center. Those physicians are eminently qualified to treat conditions. Diagnosis is what requires the great sophistication.

In some cases, therefore, the remedial effects which are desired depend upon the hospital administration and even upon the overall values of the community as a whole. Although this leaves room in which the medical school may function, there are necessarily a very large number of impediments to achieving the best possible health care service which are beyond any presently conceived educational plans. Clearly many changes might be brought about by having the medical school take over and operate the community hospital. This is not its present mission and efforts to do so would create great resentment on the part of the community hospital. Moreover, the medical school itself does not have the personnel available to do such a job at this time. It is likely that in the long run the relations between the community hospital and the medical school will become much closer with a mixing both of administrative and medical activities. It is not unlikely that the community hospital will eventually become a satellite to the medical school which will become directly responsible for some aspects of the actual medical service found in the community hospital. (1)

There is little question but that learning did occur in individuals participating in the Exchange Program, and that this learning was relevant both to physician education training procedures and to physician care of patients. Certainly this is indicated by physicians subjective evaluations of their experiences. (2)

Footnote (2), to page 101

Community Hospital Physician, Surgeon Pre

So far this kind of exchange experience will be more efficient in permitting the introduction of new ideas. It also permits making contacts on your staff so you can channel problem cases. I often make consultation to a medical center where I have felt we didn't have the equipment or first hand knowledge to give the patient the additional benefit of what is available. In one day already I have made contacts especially for renal work.

Footnote (1), to page 101

Community Hospital Physician, Surgeon Pre

There have been new things developed in my specialty. We keep up with these in journals but often we do not have any personal contact. Getting to a medical center where you can actually watch the procedure or talk first hand is more enlightening.

Community Hospital Physician, Physical Therapist Post

On the average I might return from the American Congress on Rehabilitation with two or three things I might want to do differently. I get one or two at the AMA. Here I got more because I have a better chance to observe a whole spectrum of activities. I don't think there would be as much for me next time here.

It is an open question however whether the amount learned through the exchange was equal to, greater than, or less than what might be learned through other avenues in terms of its applicability to the physicians practice. Physicians themselves, however, tended to be enthusiastic about what they got out of it. (1)

There is a major difference however in comparing the effects of the Exchange Program with those of physician attendance at national meetings. Many of the national meetings are geared for medical scholars and not as means of communicating with medical practitioners. Also, there is a continuity and the possibility of a follow-up in the Exchange Program which is lacking in attendance for most physicians at national meetings. Insofar as reinforcement is generally believed to be the differentiating factor with regard to the actual change of behavior, the Exchange Program has unique features lacking in national meetings with regard to potential effects upon physician practice.

(CF. Pattern of communications, P.18,#3, quote 5) The awareness of the potential, if not already actual, superiority of the Exchange Program approach was recognized by at least some of the physicians because it does involve the possibility of follow-up, especially through consultation on specific cases. (2)

Ideally, of course, it would be desirable to determine the actual cost per unit of advantage to patients to have physicians exchanged and ed-

Footnote (2), to page 102

Community Hospital Physician, Director of Medical Education Post

Physicians in the practice of medicine today are asked by countless people to do something about the rising cost of medical care. It would be an expensive procedure for the hospital to send a man away to the medical college for a month. It always costs more when you go away.

Footnote (1), to page 102

Community Hospital Physician, Physical Therapist Pre

I think that all of the different postgraduate teaching activities that I have attended are always very helpful to me.

Community Hospital Physician, Director of Medical Education Pre

The wrong diagnosis happens not infrequently in this hospital and in every other hospital. When other suggestions are made, the staff is very cooperative in carrying them out.

Jefferson Medical Center Physician Post

The community has a responsibility for the doctor's education. One day sessions are not worth the time it takes. At least a week is needed for continuing medical education. The physicians should be offered relief from their practice once or twice a year. He could then be sent somewhere for continuing medical education. This could be fitted into residents' training. Medical students could also help in this. Internships could be done away with and their functions taken over by fourth year students.

Jefferson Medical Center Physician Post

We discussed at some length a patient who had a urethral operation followed by a pulmonary lesion and fever. The medical consultant treated this as pneumonia with an antibiotic. No culture was made. I suspect it was an infarct.

uated in this way and to compare this with alternate techniques. Such measurement, of course, is excluded because there are no comparable measurements for alternate techniques and because it is difficult to find satisfactory "units of advantage to patients." (1) Furthermore, society itself must determine how much value it will give to patient care, whether it will be satisfied with some people getting excellent care when many more could. For the short-run, at least, it is not unlikely that the per-diem costs of hospitalization may be less where there are no elaborate continuing medical education programs conducted. Physicians, in spite of their own comfortable incomes, appeared to be somewhat concerned about medical costs in their community. (2)

Even in this hospital, however, it was possible to observe although its per diem costs were low in relation to the medical college hospital's per diem costs, the average length of stay for patients there were statistically significantly longer than for other hospitals in the country as measured by the PAS by over one day, or nearly 20% of total average patient stay in the hospital. It thus appears that a low per diem may be an expensive economy if one is thinking about the cost to the community.

It is not unlikely that eventually society will have to recognize its interest in achieving the best possible medical care for patients by educating itself to some extent with regard to what constitutes good

Footnote (1), to page 103

Community Hospital Physician, Physical Therapist

I knew that economically this would not be as rewarding as other fields.

It makes it a little easier for me to take about two weeks a year to attend meetings. I don't have their overhead. It is harder in general practice. I think that over a period of some years, this can be disastrous for some physicians. They end up giving the patients what they want and then they become convinced this is the way to treat them. I know that a man can become very shoddy and not realize this. When you get into central Pennsylvania, you think you are in Africa as far as the county home is concerned. There may be 400 patients and no physical restoration. You see this one place after another. I've seen head injury cases in a county home for 22 years and I've seen his matched case two months in the rehabilitation center and back to work. If the physicians were actually aware of how important this is, they would be more insistent. If you need some rehabilitation in this state, there is always some way to pay for it.

medical care and how to identify physicians who consistently offer their patients the best and most up-to-date medical treatment. Assuming a negative correlation between physician availability and physicians being up-to-date, society may in effect be asked to judge whether it prefers to have the services of a physician who may on occasion make a house call at night or whether it prefers the physician whose diagnosis is more likely to be correct and whose treatment of the patient is more appropriate. (1)

With regard to the present Exchange Program, the negative correlation suggested above does appear to hold. There is no evidence, however, that as a result of the program any physicians became either more or less available to their patients. It is possible, therefore, if the public will make known its desires and its willingness to pay for what it wants, that it can have both service when and where it is needed, and service which is of a better quality.

Footnote (1), to page 104

Jefferson Medical Center Physician, Post

People who attend one or two day courses tend to forget what they have learned because they return to such pressures. Sending people out to the hospital is not effective either because it is too close to the daily atmosphere. It will be effective but only with a few.

The Value of the Exchange Program as a Method of Continuing Education
for the Staff of the Community Hospital

Apart from possible effects of the program on the communications system at the community hospital and upon the quality of medical care offered at the community hospital, it is fair to ask how the physicians who participated in the experience felt about it. Did they like it? Would they like to do it again? Did they feel that it had any useful effect upon the hospital as a whole? What should be done differently in order for them to get more from it?

It is recognized that as a method of continuing medical education for any given physicians from the community hospital who participated in the Exchange Program, like that of any other isolated educational endeavor, its value was necessarily limited. It did not and could not solve all problems. Exchange visits cannot and should not replace all other forms of education, especially reading and participating in the medical conferences and other educational activities at the community hospital. Although some kind of a "Sabbatical" program or its equivalent may be desirable for doctors, continuing education, to be most effective as a means of learning and influencing behavior it must be continuous as well as occasionally extended in length and concentrated. (1) In this regard it is fair to note that the individual physician's personal exchange visit at the medical school was discontinuous and limited in length in its very nature. However, it was believed that the presence of physician

educators from the medical college at the community hospital would tend to extend the effects of individual physician's visits as would their contact with one another. The program was not completely integrated into the overall educational program at the community hospital, however. This could be more fully accomplished by relating the medical audit to the educational program, by directing physician reading through introducing journal clubs with Jefferson Medical College faculty participation, etc.

Most physicians, however, in evaluating the program tended to think more specifically in terms of their experiences at the medical college rather than in terms of the other indirect influences of the program upon them. Moreover, as with most individuals, the physicians showed little awareness of the potential utilization of their more routine and day-to-day activities as opportunities for learning or for teaching. Some of the younger physicians were therefore very enthusiastic about the Exchange Program and indicated that they felt they had learned more in their week than in any comparable period since leaving medical school. Although there is little doubt that this week offered for those interested in it an opportunity for an intense learning experience, one wonders how many learning opportunities had merely been overlooked following medical school or not perceived as such.

There was no emphasis placed upon requiring physicians to learn fixed

amounts of information as a result of their experience with the Exchange Program. This might easily have aroused negative reactions as some of the physicians would have realized that in terms of factual content, they might have gotten more by spending a like amount of time reading or participating more actively in the medical educational activities at their own hospital. The major difference, of course, is that they did in fact spend the time on this Exchange Program which they were not otherwise likely to have spent. They were committed by their presence at the medical school to educational activity of some intensity for a reasonably prolonged period of time which otherwise no doubt would have been devoted to treating patients with routine problems. In all cases physicians were able to make alternate arrangements for the care of their patients. During this time of exposure to the academic atmosphere of the medical college observing and participating in both the formal and the informal medical educational activities going on there, the community hospital physician was completely uninterrupted by his own usual office or hospital routine. It was impossible for physicians not to become absorbed to some extent by what was going on at the medical school as they themselves noted. But what is important is not what they did nor did not learn but that they perceived the difference in atmosphere between the medical college and the community hospital and they perceived also that at the medical college there were more

opportunities for their own continued learning. This led some of the physicians to think about developing more fully the climate of learning at their own institution albeit without their expecting to equal or to surpass the medical school in educational activity. Some other physicians, while acknowledging the difference in the level of educational activity of the two institutions, indicated that this was simply in the nature of things because of their greater involvement in patient care activities than the medical school faculty. Nevertheless, because the participating physicians did not have to defend what they did or did not learn from their experience in the program, it was possible for many physicians to conclude that there was considerable potential in their own community hospital for a more active educational program, one which would meet the needs of the staff more adequately than was being done at the time. In short, the physician from the community hospital was given the opportunity to be pleasantly stimulated intellectually in a different medical environment and one more attune to educational activity.

Because the experience was in fact pleasant for all physicians who participated, nearly all of them indicated that they would like to repeat the experience on an annual basis. Some felt that the experience was so valuable that their presently non-participating colleagues should do so in the future. This, of course, would greatly strengthen

is that the patient died. What he had would have been correctible,
but what he was being treated for was not correctible.

Community Hospital Physician, Surgeon Pre

I can't think of any negative results that would occur from a more
intensive educational program at my hospital.

Community Hospital Physician
General Practitioners Speaking in Group Discussion

"The people coming here have given me a feeling of status. They
talked to me with respect." I am surprised that a medical school
such as yours is trying to do something for people in my status."

Footnote (3), to page 108

Community Hospital Physician, Surgeon Pre

I heard quite a few favorable comments and nothing derogatory about this program.

Community Hospital Physician, Director of Medical Education Pre

The only negative effect of this program is that more people won't come. I've really seen no negative results at all. We did get some argument between one of the surgeons from Jefferson and a new staff man we got from the University of Pennsylvania. Nobody has resented it. The visitors from Jefferson have gotten the highest praise for them professionally, socially, and every other way. The only thing that upsets me is the poor turnout of our own staff. When I talk to them about it, they say, "I forgot," "I had to do this," "I'll be there,"... I was almost about to jump off a cliff when Dr. ____ was here. We had a leading figure in the community here on two occasions being treated for several different conditions none of which he had. Dr. ____ saw him, discussed him at a conference, made an outstanding presentation. The man died about four days later and he did have what Dr. ____ said. But there was a very poor turnout. It's not the end of it when there is a wrong diagnosis like this. We start in confirming on what Dr. ____ says but the unfortunate thing

good. Overall I found everything quite interesting and quite instructive.

Community Hospital Physician, Pediatrician Post

I had a very cordial visit. I was taken around by the head of the department and Dr. _____. I've been rather favorably impressed with the department in general. It's been a wonderful week. I enjoyed a number of the conferences very much, especially one on genetics by Dr. _____. One by Dr. _____ on thalassemia was very interesting. It was good to be in an academic atmosphere. It's unique in that the men do not have big practices so that they can devote their time to teaching and to research. There is an interchange of ideas because the different men are interested in different phases.

They allowed me to precept the medical students and it was most enjoyable.

go along. We met and became reacquainted with individuals who have ability to teach and keep us informed. If we are interested in some special phase of patient treatment, we know where to get someone who might not be so strange to us. I really can't say that I was made of any major deficiency. There was nothing I was grossly upset or disturbed about.

Community Hospital Physician, Physical Therapist Pre

I attend the surgical conferences at the community hospital regularly. I attend the medical conferences periodically because of the time. I communicate at these conferences. But it is interesting, when you go away from home, you communicate more.

Community Hospital Physician, Surgeon Post

This is a tremendous experience. There's no question about it.

Community Hospital Physician, General Practitioner Post

I enjoyed very much meeting with the psychiatrists on several occasions. For the most part it was on a one to one basis where I could sit down and pump questions concerning things that I am interested in. It is very helpful and very good. I was primarily interested in depressive reactions. Their approach is a little different than mine. This is a regional thing and will vary. But the idea of one-on-one is quite

the stimulus of the college atmosphere is an experience that I'm very happy about because I can sense the pulse of what is going on.

Community Hospital Physician, Internist Post

I felt very good to be called upon here in the conferences by the professor of medicine and I did not hesitate to interject some comments. This is an area in which I am very much interested. I like to teach. I did not bring up information these men did not know because these men are sharp but all teaching is an exchange of ideas and I contributed in an area which I thought might be glossed over a bit.

Community Hospital Physician, Internist Pre

I don't believe my experience here is going to change things very much in my professional life. I'm still very much interested in present day medicine. I'm interested primarily because of the fact that I'm in practice and I want to know the new approaches to diseases. My interest is not unchanged; I would say it has been stimulated.

Community Hospital Physician, Internist Post

I have enjoyed the experience very much. I enjoyed Dr. ____'s visit with us also. This experience has pointed out the source of material we can draw upon to have our continuing medical education program

Footnote (2), to page 108

Community Hospital Physician, General Practitioner Pre

I'm thankful for this program. I can't offer you much but you can give me a lot. When I come down here like now, I'm one on one, a professor and me. I pump him, I pump him good because I want to learn. In our exchange of views, I'll tend to lean a little towards their when we're done, because these guys are far more versed than I am; they read in areas I don't. I don't feel I can offer them a lot but they can offer me as much as I can take home.

To me this is out of this world if you can give me one on one with the medical school faculty.

Community Hospital Physician, Internist Pre

I think this program that is being carried out now has great possibilities for the future. I'm very excited about it. I know what the visit of Dr. _____ meant in the community hospital. The physicians were very excited about it. It was not put on. The house staff, nurses, and doctors felt it. The idea is that we are once again having time to hear the experts, to be by the bedside with the expert. Even with routine diabetic patients he made some points that impressed us all. It restored my faith in continuing medical education. The average physician in private practice is so busy that I find that

Footnote (1), to page 108

Exchange Conference

Dr. _____ reported that there were many things he would like to cover that he did not have time for.

the educational base in the community hospital. (1)

Some of the physicians commented positively and spontaneously as follows with regard to how they felt about their experience in the Exchange Program. (2) Probably the best measure of the acceptance of the program was that the staff voted unanimously to continue it.

Naturally one would also look for negative effects or unanticipated side effects. As the program was run, there were none reported.

In fact, even general practitioners who were barely in contact with the program had good words to say about it insofar as they felt that they were treated with respect and dignity by the visiting academic faculty. (3)

The program however was something of an economic luxury for the community hospital. It was not asked to contribute money to the program nor to assume any special obligations in terms of its own growth or pattern of activities. As such it could have been continued indefinitely, pleasantly and not-unconstructively. But such a program could not provide a model for the hundreds of hospitals which would also like to have a similar form of educational assistance from a medical center which cost them nothing (apart from lost practitioner time and income) and which placed no burdens upon them. Although it may be desirable for medical schools to invigorate the educational

programs of community hospitals on a very broad basis, eventually these programs must become independently strong and self-sufficient. It must be recognized that the economics of things does not permit the medical college to provide the faculty for all of the community hospitals: there are not that many in the medical school's faculty. Moreover, there is reason to suppose that with greater internal organization and effort, the community hospitals could produce their own faculty who will be quite as capable as the medical school faculty; there is no evidence that the intellectual potential of community hospital physicians is any different from that of the medical college faculty.

The community hospital educational assistance program initiated in this exchange of physicians activity is concerned not with continued "spoon-feeding" of physicians in terms of their educational needs but with stimulating them to assume more fully their own educational responsibilities and developing their own latent potential for self-instruction on an institutional basis. It was therefore decided before the exchange of physicians had been completed to require more than the passive cooperation of the community hospital physicians in the program in its subsequent phase but to involve them actively in a variety of things.

To some extent, spontaneously, some of the community hospital physicians utilized the Exchange Program in order to press for needed

changes in the educational program at the community hospital. An immediate result was the formation of an Educational Planning Committee which concerned itself with proposing educational changes for the hospital. This was consistent with the immediate reactions of the physicians participating in the program coming to recognize the role of their hospital as an educational institution as well as a service institution. Another immediate reaction of the hospital was to attempt to enter into an immediate and broad affiliation with the medical school. Although the hospital does not appear to be ready to assume the responsibility for training medical students, and although there are again no doubt ulterior motives in terms of attracting house staff to the hospital to provide greater coverage for busy physicians, it is reasonable to suppose that the timing of these events, unprecedented in the history of the hospital, was related directly to the Exchange Program and its effects upon the thinking of physicians with regard to their educational mission.

Moreover, the unanimous willingness of all of the staff physicians at the community hospital to continue the Exchange Program in a new and more structured form also suggests that the Exchange Program was successful in alerting physicians at the community hospital to the opportunity for them to continue their education more effectively by developing their own internal educational program.

The Exchange Program should not therefore be construed as an alternative to other forms of continuing medical education, especially those conducted at the community hospital by itself. Under some conditions, however, it may be a highly useful educational supplement. It appears to awaken in some physicians an awareness of their own educational needs and those of their hospital while also apprising them of their actual and potential resources in meeting those needs. For other physicians, those already aware and concerned, it provides a kind of outside support with which to approach their less concerned colleagues. The role of the Exchange Program therefore can be described as limited in scope, temporary in duration, flexible in format, and catalytic in effect.

The Value of the Exchange Program for the Medical College Faculty

With regard to the value of the Exchange Program for the medical college faculty, it is clear that their needs and interests are quite different from those of the community hospital physicians. Although it is possible for a visiting faculty member to find an "interesting case" in the community hospital, he is not likely to be exposed there to a sufficiently great wealth of case material, inquiring individuals, or other educational experiences which would justify identifying the program as a method of continuing medical education for him. From the strictly academic point of view, he can do much better in his own institution. Some of the medical college faculty suggested, in fact, that they became bored after two or three days at the community hospital and they had to make efforts to find new things to do to keep their minds active. One individual commented that he was impressed by the general absence of intellectual curiosity at the community hospital and he felt that the physicians there did not realize the importance of understanding what was going on in research activities at the medical college.

On the other hand, nearly all of the medical college faculty expressed interest in learning about the practical problems of men in the field and most were quite favorably surprised by the high quality of medical

practice they saw at the community hospital although all were prepared to identify deficiencies there at one level or another. The exchange visit for these men was thus reassuring but not medically instructive. It was striking, however, how few of the medical college faculty had any sort of idea about the educational needs of the community hospital physicians or how effective or ineffective they may have been in other programs of continuing medical education they had participated in in the community hospitals. Some felt that they could discern their effectiveness by observing the facial expressions of their audience but most considered evaluation in any meaningful sense to be non-existent. For most of these physicians from the medical college, this exchange visit was their first opportunity to observe activities in a community hospital over an extended period of time. Some of them, however, felt that the real test lay not in the community hospital but in the physicians' office practice.

Assuming continuing medical education to be a reasonably permanent fixture in modern medicine and that the medical college faculty will continue to play an important role in continuing medical education programs, it is important for these faculty men to have some idea about what happens at the community hospital, what the opportunities are for improving the quality of physicians' medical knowledge and medical performance. Exchange visits probably have a unique potential in this regard. There is simply no alternative to have a faculty

man go to the community hospital and observe the behavior of the physicians there and to interpret this in relation to the environment there. Some of the faculty who participated in the exchange became very much involved in the problems they saw "in the field" and even wrote some lengthy informal papers outlining their experiences, the problems they saw, and what they thought might be done to alleviate matters.

The Exchange Program thus allows the academic physician to educate himself with regard to many of the practicalities of one health service delivery system with which he might not otherwise be familiar. Insofar as academic physicians are concerned mostly with the training of medical students whose main medical activities will be concentrated in community hospitals, this opportunity to develop some first hand experience with these institutions has obvious advantages.

In selected areas, however, it may be expected that the community hospital will have accepted some advanced technology not yet developed at the medical college. In the present instance, the community hospital had in operation a coronary care unit prior to there being one set up at the medical college. This gave the visiting academic physicians an opportunity to see such a unit in operation prior to having one in their own institution. Most of the academic visitors commented upon this and spent some time observing its operation.

Recommendations with Regard to the Further Development and Utilization of the Medical College/Community Hospital Exchange Program

The initial phases of the Exchange Program have given knowledge to the medical college with regard to the community hospital and its problems. On the basis of this knowledge, it seems likely that to proceed with a simple continuation of the activities of the first phases would produce neither new significant information nor any change in the pattern of communication and continuing medical education at the community hospital. Simple continuation of what was successful at the outset would lead eventually to arrested development. Many educational programs suffer failure to grow and to respond to the effects of the programs themselves.

Where the parties in an educational exchange program are already keenly interested in learning and in meaningful communication, it is quite likely that the less structure there is to the program, the better it is. The assumption is that people are likely to participate actively in meaningful communication with one another except as they are inhibited from doing so for one reason or another. Learning is thus perceived as the natural activity and communication its means. Where the impediments are great, however, meaningful communication and learning may slow to a trickle. Observation of the community hospital revealed a number of serious communications impediments. Some of these related to negative attitudes engendered toward

Footnote (1), to page 116

Community Hospital Physician, Obstetrician Pre

There is a great deal of recognition of the problems. We have talked about them. This is a time to be critical of weakness. We are devoted to the hospital and are afraid of a plateau with our present facilities. If we sit back, take care of our patients, get fat and rich ---- it just doesn't work that way. In ten years who will we have to come along and fill these gaps?

education arising in the individual well before medical school. Negative experiences in medical school for others no doubt added to this. However, as has been seen above, rather serious obstacles to effective communication at the community hospital were also perceived in the organization of the community hospital and in the quality of educational direction and leadership offered there.

It was therefore felt that the probability of making the changes desired would be most likely to be increased by developing the Exchange Program as a more structural program with greater involvement of community hospital physicians.

The first phases of the Exchange Program were concerned with developing a climate of acceptability for the concepts of continuing medical education in the hospital on an intensive basis. During this time, as many ideas as possible were encouraged to emerge on the part of the community hospital physicians. They were stimulated to think, to compare, to evaluate, and to become perhaps slightly dissatisfied. (1)

Change, of course, is virtually impossible in an atmosphere characterized by complete satisfaction. During this period, the latent educational leadership of the community hospital was uncovered and lines of communication established with it. Thus, to the extent that the Medical Director/Director of Medical Education was perceived as himself inhibiting communication in areas at the community hospital, alternate contacts were established between the medical college and

Footnote (1), to page 117

Jefferson Medical Center Physician, Post

In the beginning I would run this type of program exactly the same way with another hospital, bringing out change from within. This is the best way to do it. Get leaders on the scene and support them. They can introduce the changes you wanted to make in the first place. If you begin with a structured program, what they do is to abdicate their own responsibilities. You need to have direct personal involvement. Without that you don't have the self-criticism which is important.

the community hospital physicians. (1)

Had the program been left to the community hospital physicians, however, they would have continued it as it was with no changes. Some of the physicians expressed themselves explicitly on this point. In discussion, nevertheless, as the program approached the end of the initial phases, suggestions from the medical school were given to the community hospital physicians to think about subsequent phases, and it was indicated to them in discussion that the subsequent phases should be characterized by greater "structure." It was emphasized that such structure would not be at the cost of flexibility but that the routine of the academic and community hospital visitors should be defined in relation to more specific educational goals. Throughout, the clear implication was that the community hospital would be expected to become increasingly active in the design of the exchange visits and in staffing the proposed educational activities to be conducted at the community hospital. Whereas previously the community hospital physicians somewhat passively waited to be told by the Medical Director/Director of Medical Education what to do and when to do it, now it was made clear that they were expected to do much of the planning themselves and that neither the Medical Director nor the medical college would determine everything that would be done. It then became evident that the physicians at the community hospital were not accustomed to participating in planning educational activities.

The Medical Director delegated to various individuals only the responsibility of performing the various educational functions at the hospital but not that of planning them in the first place. Committee meetings for such committees as existed met infrequently and perfunctorily. Even the Educational Planning Committee formed in response to the Exchange Program would not be called a very active committee and actually accomplished very little having no clear perception of its role. Consequently the staff physicians at the community hospital did not perceive it to be their function to consider alternative educational programs from those already set up by the Medical Director/Director of Medical Education.

The key concept in the further development of the Exchange Program thus involves greater involvement on the part of the community hospital physicians in the overall planning of educational activities at the community hospital and in their implementation as well. It also implies that educational activities be perceived in a much broader context including the activities of the medical audit committee and crossing departmental lines. Especially important also is the idea that educational activities should be subject to closer evaluation. Community hospital physicians showed no awareness in the initial phases of the Exchange Program of the importance of evaluating educational activities. The proposed more "structured" educational

exchange is based upon the concept of evaluation both of the need for the program and of the goals which have been set forth being achieved. Community hospital physicians by their participation in the medical audit and by their planning of educational exchanges based upon deficiencies revealed through the medical audit will become aware of the role of evaluation in their educational activities. It is hoped that in this period the community hospital will generate its own educational commitment so that with a minimum of guidance from the medical school, it can continue to have its educational programs function more effectively in relation to need.

Suggested Modifications for Improvement of Staff Exchange Programs
Based Upon Experience with the Current Exchange Project

In general the project seemed to run smoothly and no major problems were encountered. Insofar as the Exchange Program was designed not to threaten anyone at the community hospital and the community hospital was not given any major responsibilities to assume, no problems would be expected. The following represent some of the minor aspects of the project which might have been handled in other ways.

1. Collection of data from the community hospital. The community hospital is not really organized very well to make observations about its own functioning. More careful preparation of community hospital personnel for the collection of data would have been desirable. This would apply to attendance of physicians at the library and medical conferences. Efforts are being made in this direction at this time.
2. Establishment of an educational planning committee. In order to spread the impact of the program earlier and to remove it from the hands of a single individual, the Medical Director/Director of Medical Education, it might have been desirable to press for the earlier establishment of an educational planning committee to consider problems relating to scheduling, etc. However, if this is done too soon, the "wrong" (i.e., less motivated) individuals may get on it.

Also, it is highly desirable for such a committee to be established spontaneously as happened in this instance.

3. Personal contact with non-participants. Communication with the physician staff was left to the devices of the Medical Director/Director of Medical Education. His preferred mode of contact as has been noted was to send out form letters to physicians on his staff. These are not followed up by him at his office. It would be desirable for these to be supplemented with personal contact being made to non-participating physicians by those interested in educational activities at the hospital. This could be one of the activities directed by the educational planning committee in its assessment of its resources. However, here again this should not be done too soon because there is no advantage in getting half-interested individuals involved in a project before those who are most interested in it have consolidated what they intend to do..

4. Anticipation of the dependency needs arising in the community hospital.

Relatively early it became clear that there would develop some interest on the part of the community hospital in "affiliating" with the medical school. Premature affiliation was not encouraged but it is possible that some of the energy behind this move originating in the community hospital might have been diverted to strengthening the independent status of the hospital through increased self-appraisal of

the educational program conducted there.

Probably the major modification, however, relates to the selection of the community hospital itself. In retrospect the overall competence of the Medical Director/Director of Medical Education appears to have been overestimated. His own appraisal of himself appears to have been more appropriate. As a board certified internist from a leading medical college he appeared to have the background and experience essential to understand the objectives of the Exchange Program. In fact, however, as subsequent events showed, one of the most serious obstacles to effective communication in the hospital was in the person of this individual. Without entering into distasteful political maneuvers at the community hospital level, it is not likely that he could be removed as an effective block to significant change there. His own attitude towards education was succinctly summarized in his statement that the job of a Director of Medical Education requires only five minutes attention a day. He himself did not understand the educational role of the community hospital and he therefore never spontaneously made suggestions or communicated ideas arising from others in his staff to the medical college. Retrospectively, the signs are clear in the fact that during his many years as Medical Director/Director of Medical Education, he did not press for any full time heads of departments, he did not respond to opportunities offered to him to participate in programs of continuing

medical education with any medical college, and he did not develop an outstanding educational program for house staff or others at his hospital. This negative attitude towards education, or, at least, this failure to translate a more positive attitude into accomplishment, was not an issue in the first phases of the project when a passive orientation on the part of the community hospital was acceptable. When the community hospital was called upon to share in planning, etc., the problems came to the surface and quickly became acute. Unless, therefore, there is already a strong Director of Medical Education committed to education or a significant and even somewhat dramatic change at the top of an institution, it becomes doubtful whether change at other levels will be very deep. The community hospital is thus now in the position where there are many younger men on the staff who are eager, partly as a result of their experience with the Exchange Program, for there to be a much more active and meaningful educational program at their institution but who lack the power themselves to implement it and who are not given either the guidance or support they need from the top level of the institution. With a new full time chief in the department of medicine, pressures for change will increase. However with existing organizational structure and limited communication within the institution major problems may be forecast. An important modification for future experimentation would be therefore to select an institution to work with in which there has been a recent change at the top and in which a vigorous and

aggressive (but tactful) physician has become Director of Medical Education and whose institution is prepared to support him in educational experimentation or where there already is a healthy commitment to continuing medical education. It is possible that some of the more suitable hospitals will not be the "better", wealthier, and more respected hospitals but those which are reasonably far down the totem pole in terms of prestige, but which recognize this and wish to do something about it. Putting obligations of the community hospital into writing under these conditions may be redundant to a large extent although this may help the new Director of Medical Education to support his own requests from his staff and board of governors.